SNAPshot 3.90 User Manual

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Australian Health Services Research Institute
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Version 1.4

www.pcoc.org.au

PCOC is funded under the National Palliative Care Program
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About the Palliative Care Outcomes Collaboration (PCOC)

The Palliative Care Outcomes Collaboration (PCOC) is a national program that utilises standardised validated clinical assessment tools to benchmark and measure outcomes in palliative care. Participation in PCOC is voluntary and enables palliative care service providers to improve practice.

Palliative care services participating in PCOC routinely collect data, which is submitted to the PCOC National Office for the following two reporting periods. Data is submitted to PCOC between:

- Jan 01 – Feb 28 for the most recent Jul 01 – Dec 31 period (1st Reporting Period)
- Jul 01 – Aug 31 for the most recent Jan 01 – Jun 30 period (2nd Reporting Period)

Submitting data to PCOC can be an iterative process. The first set of data extracts from a service are loaded into the data base for the purpose of data quality checking. Services receive an error report, and are given the opportunity to amend their data, if required. Once corrected the data are again extracted by the service and submitted to PCOC, to undergo the same process. This process of error checking may be required to happen multiple times until the data are free of errors, the service determines that remaining errors cannot be fixed or the cut-off date is reached.

After the closing date for the database, PCOC undertakes a further data cleaning process before performing analysis and benchmarking and generating individualised reports for participating services.

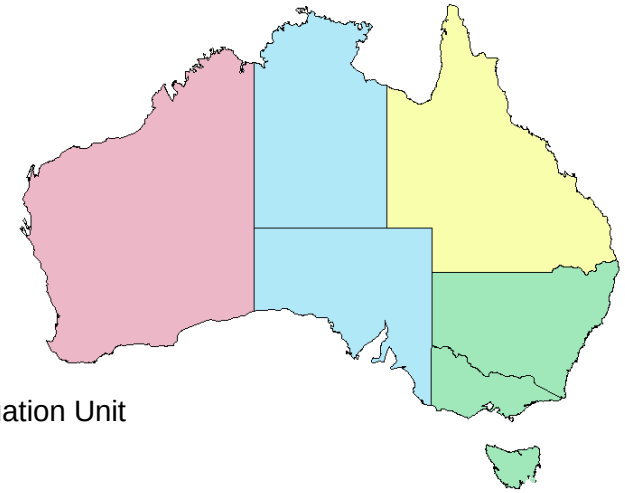
PCOC is a collaboration between four centres, each with a Chief Investigator, and is divided into four zones for the purpose of engaging with palliative care service providers. The four PCOC zones and their Chief Investigators are:

Central Zone
Professor Kathy Eagar
Australian Health Services Research Institute
University of Wollongong, NSW

North Zone
Professor Patsy Yates
Institute of Health and Biomedical Innovation
Queensland University of Technology, Qld

West Zone
Assistant Professor Claire Johnson
Cancer and Palliative Care Research and Evaluation Unit
University of WA, WA

South Zone
Professor David Currow
Department of Palliative and Supportive Services
Flinders University, SA



The National office, responsible for the PCOC National Longitudinal Database and routine reporting and analysis, is located within the Australian Health Services Research Institute at the University of Wollongong.

For more information on PCOC visit **www.pcoc.org.au**

Tips to avoid errors when using SNAPshot to enter PCOC data

SNAPshot is a software program that has been adapted to allow PCOC data collection. The following points will assist users to reduce errors in data collection:

- In addition to the mandatory fields (red) enter data items included on the V3 PCOC forms. Not all data items listed in SNAPshot are required for PCOC.
- Assessment scores must be recorded when reason for phase end is discharge. Scores are recorded in the **PallCare screen** in the End Column. Use *not assessed* code if the patient was unable to be assessed at discharge
- For Episode Type **do not use** *consultation service* code 5
- Enter Postcode in the **Patient Screen** under usual address
- Enter State in the **Patient Screen** under usual address
- Enter Language in the **PCOC Screen**

For assistance please contact us on 02 4221 5092 or pcoc@uow.edu.au

Acknowledgments

Prepared by David Fildes, Sam Allingham, Sabina Clapham and Linda Foskett, Australian Health Services Research Institute, University of Wollongong, January 2013

PCOC acknowledges the work carried out by Debra Hinton in her publication:
Hinton D (2005) ***Using SNAPshot V3.6 to collect Palliative Care Data.*** Centre for Health Service Development, University of Wollongong.

PCOC also acknowledges the AROC team in their publication:
AROC (2007) ***Using SNAPshot V3.80 to collect the AROC version 3 dataset.*** Centre for Health Service Development, University of Wollongong.

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1 Purpose of this guide

This is a guide for staff using SNAPshot software to enter the Palliative Care Outcomes Collaboration (PCOC) Version 3 dataset.

1.1 What is SNAPshot?

SNAPshot is a software program that allows palliative care services to collect the information required to participate in the PCOC reporting and quality improvement exercises.

SNAPshot was originally designed to collect 'SNAP' (Sub-Acute and Non-Acute Patient) information. It was not specifically designed to collect PCOC information, with PCOC specific items being added over the years. As a result, information required for PCOC is entered into a number of different screens within SNAPshot.

To reduce the burden of data entry, some fields can be defaulted to the most common code or response for your facility/service (see Appendix 1 for how to set up defaults).

1.2 Logging on to SNAPshot

To open SNAPshot:

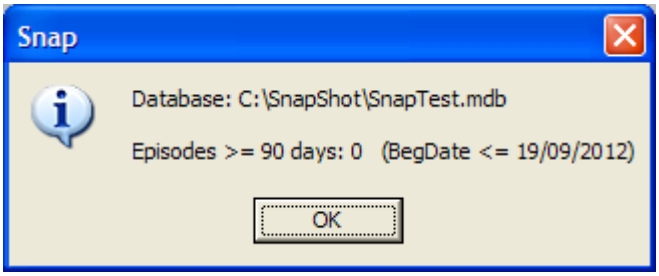
1. Double click on the SNAPshot shortcut on your desk top

Shortcut to SNAPshot

or

2. click Start -> All Programs -> SNAPshot

When SNAPshot opens, a pop-up window will appear showing the location of the database SNAPshot is pointed to and gives a summary of episodes requiring a 90-day review. The 90-day review is not relevant to PCOC. Click OK to make the screen disappear.



Next, press **Shift + F7**. A pop-up will open asking you to enter the facility password to open the database. The default password is 'admink'.

1.3 The SNAPshot Main Screen

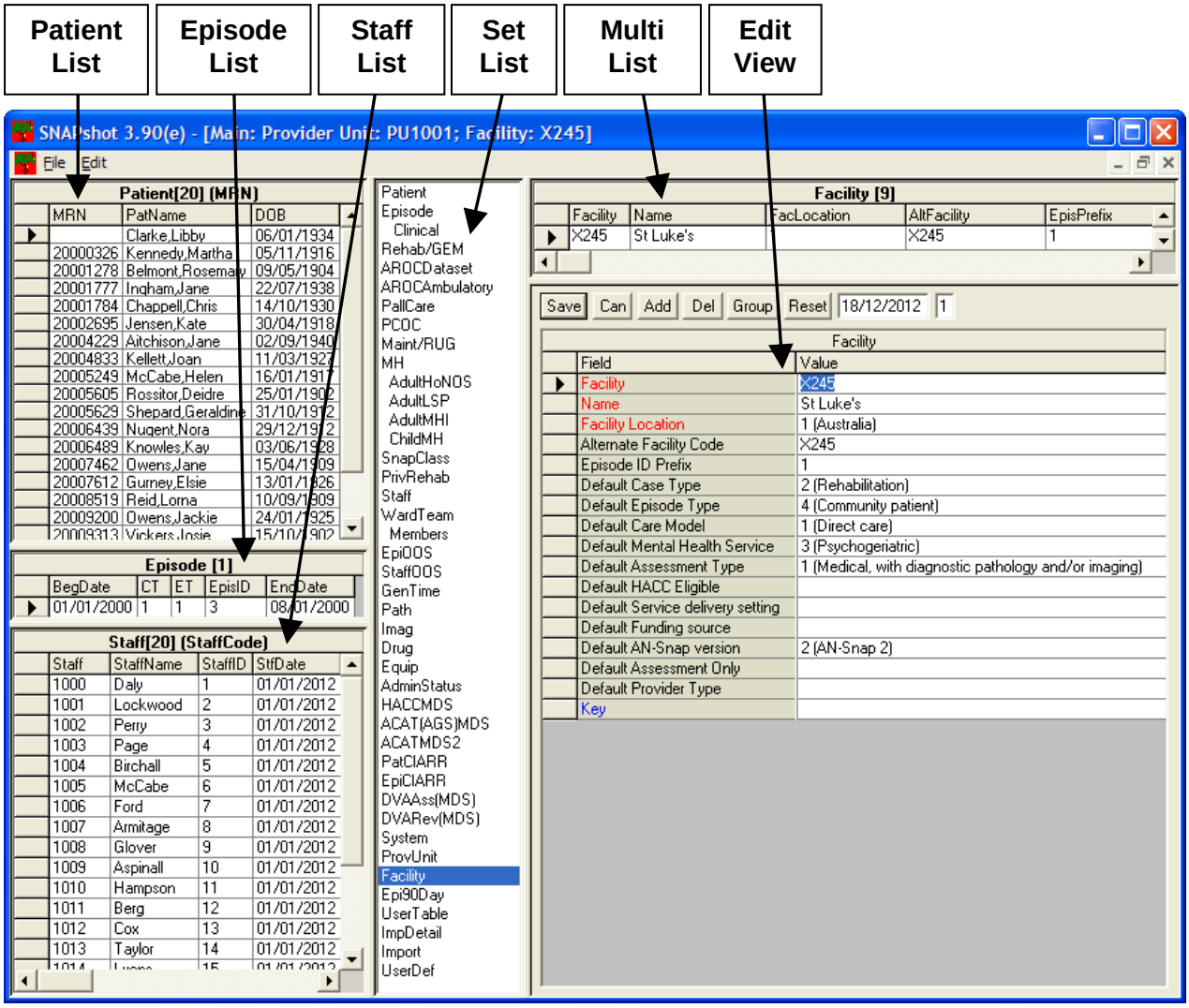
The Main Screen is where information is recorded about a facility, its staff, its patient's personal information and their health status.

The Main Screen is divided into six parts:

1. Patient List
2. Episode List
3. Staff List (not used for PCOC)
4. Set List
5. Multi List
6. Edit View

An example of the SNAPshot Main Screen can be seen in Figure 1 below. In the bar at the top of the Main Screen, the active Provider Unit and Facility are shown. Users should check that these are correct before starting to enter data. Section 4.2 outlines the process to change/reset the Provider Unit and Facility.

Figure 1 Example of the SNAPshot main screen



1.3.1 Different parts of the Main Screen

Patient List
The 'Patient List' displays the Name, Date of Birth and Medical Record Number (MRN) of the patients that have been registered by your facility.

Episode List
The 'Episode List' shows each of the Episodes that have been opened for the patient selected in the 'Patient List'. The Episode List displays the date the episode commence (BegDate), the Case Type (CT), the Episode Type (ET), the Episode Identifier (EpisID), and the date the episode ended (EndDate), if applicable.

Staff List
The 'Staff List' is not used in PCOC

Set List
The 'Set List' shows all the different data sets contained within SNAPshot. The data set selected in the Set List is displayed in the Edit View window. Once selected, it is possible to make changes or additions to that data set. The set list contains many more data sets than required by PCOC. More information about which data sets are relevant to PCOC can be found in Section 2.1.

Multi List
The 'Multi List' contains various lists depending on the data set currently selected. For example, in the 'PallCare' screen the multi list will show all previous phases entered for the patient selected in the patient list.

Edit View
The 'Edit View' is where information is added, deleted, edited or updated for the various data sets. If the patient data set is selected from the set list, then all of the fields for the patient data set are displayed in the edit view. This allows changes to be made to this data set.

1.3.2 Moving Around the Main Screen

Point and click with the mouse to move to another field or another part of the screen.

Or use the following 'short-cut' keys:

- Use the F6 key to move from one part of the Main Screen to another.
- Use the Enter or Tab keys to move to the right or down to the next field. Use the Shift + Tab key to move to the left or up to the previous field.

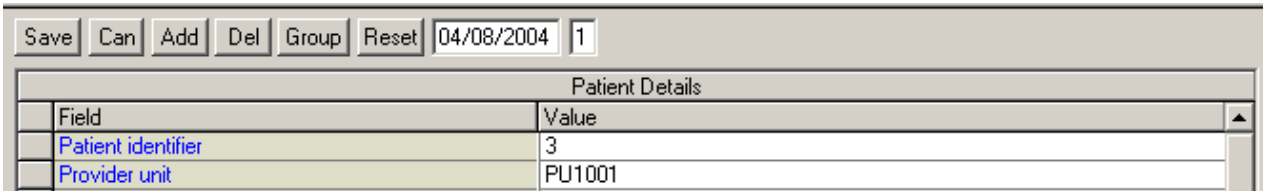
See Appendix 1 for a complete list of 'short-cut' keys.

1.3.3 Making changes or additions

The Edit View

The 'Edit View' (refer to 0 above) is where information is added, deleted (with due care), edited or updated for the various data sets.

Figure 2 Transaction buttons at the top of the 'Edit View' screen.



Choose the data set that you want to make changes or additions to from the set list.

Click **Add** to create a new record in the data set.

Click **Save** to save a record that you have added or changed.
Before you can save a record you must move the cursor out of the field that you have changed by hitting the 'Enter' or 'Tab' key or by using the mouse to click in another field.

Click **Cancel** to cancel any changes that you have just made.

Click **Delete** if you want to delete a record from the data set.
A warning message will ask you if you are sure that you want to delete the record.

The **Reset** button is used to select a different Facility and Provider Unit, it may also be necessary to re-select the facility and provider unit after the database has been moved or restored.

The **Group** button is used to group the data into an appropriate SNAP class (See Section 4).

1.4 General Operations

The *SetList* segment lists all of the data sets that you can edit. When you click on a data set name – such as 'Patient' or 'PallCare' – the fields for the data set are displayed in the EditView segment. For the purpose of PCOC data entry the 4 data sets used are **Patient**, **Episode**, **PallCare** and **PCOC**.

For some data sets – such as 'Patient' – when you make the selection a list will appear in the MultiList segment and the currently selected patient record will appear in the EditView.

1.5 Entering new data into data fields

Many fields such have a drop down list with a code for each item. In these fields, you can either type the code directly into the field or make a selection from the drop down list. You can press **Alt + Down Arrow** together to open the drop down menu for the data field that you are in.

Date formats are flexible – for example 01 Jan 2013 can be entered as 1/1/13 but it will be displayed as 01/01/2013. Note that separator character such as slashes or spaces must be entered.

BE CAREFUL WHEN ENTERING DATES!

If only the day and month are entered SNAPshot will assume it is for the current year – eg SNAPshot will convert an entry of '1/1' to 01/01/2013. This can cause errors when entering a patient's Date of Birth or entering information from the previous year.

1.6 Editing existing data

To edit an existing record in EditView, simply click on the relevant field and enter data. Before you can press the Save button to save changes you must move off the field you have just edited (pressing the Enter key is fine) otherwise you will receive an error prompt.

Mapped fields

Many data items such as Mode of Episode Start are 'mapped' or copied from one Data Set to another. This minimises double data entry. Other data items such as the Episode Identifier are 'automatically generated' by SNAPshot.

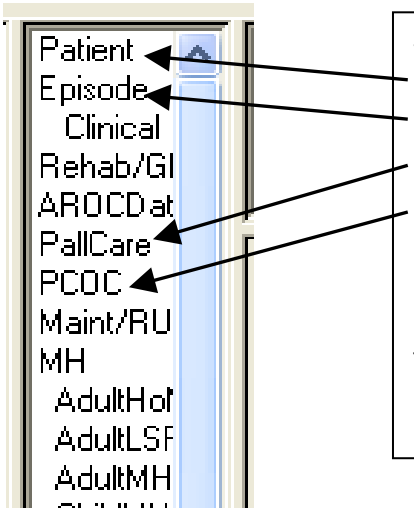
Mapped or automatically generated fields are coloured **BLUE**. They are 'read-only' and cannot be changed.

2 Entering PCOC patient information

2.1 The PCOC data entry screens

Patient information for the PCOC dataset is mainly entered into SNAPshot in 4 screens, selected from the Set List, as highlighted in Figure 3.

Figure 3 Screens in the Set List used to enter the PCOC data set



Screens used for entering PCOC data

- Patient screen
- Episode screen
- PCOC
- PallCare

Most screens contain more data fields than those required by the PCOC V2 dataset. Non PCOC dataset fields do not need to be completed for PCOC reporting purposes.

2.2 Entering information into the 'Patient' screen

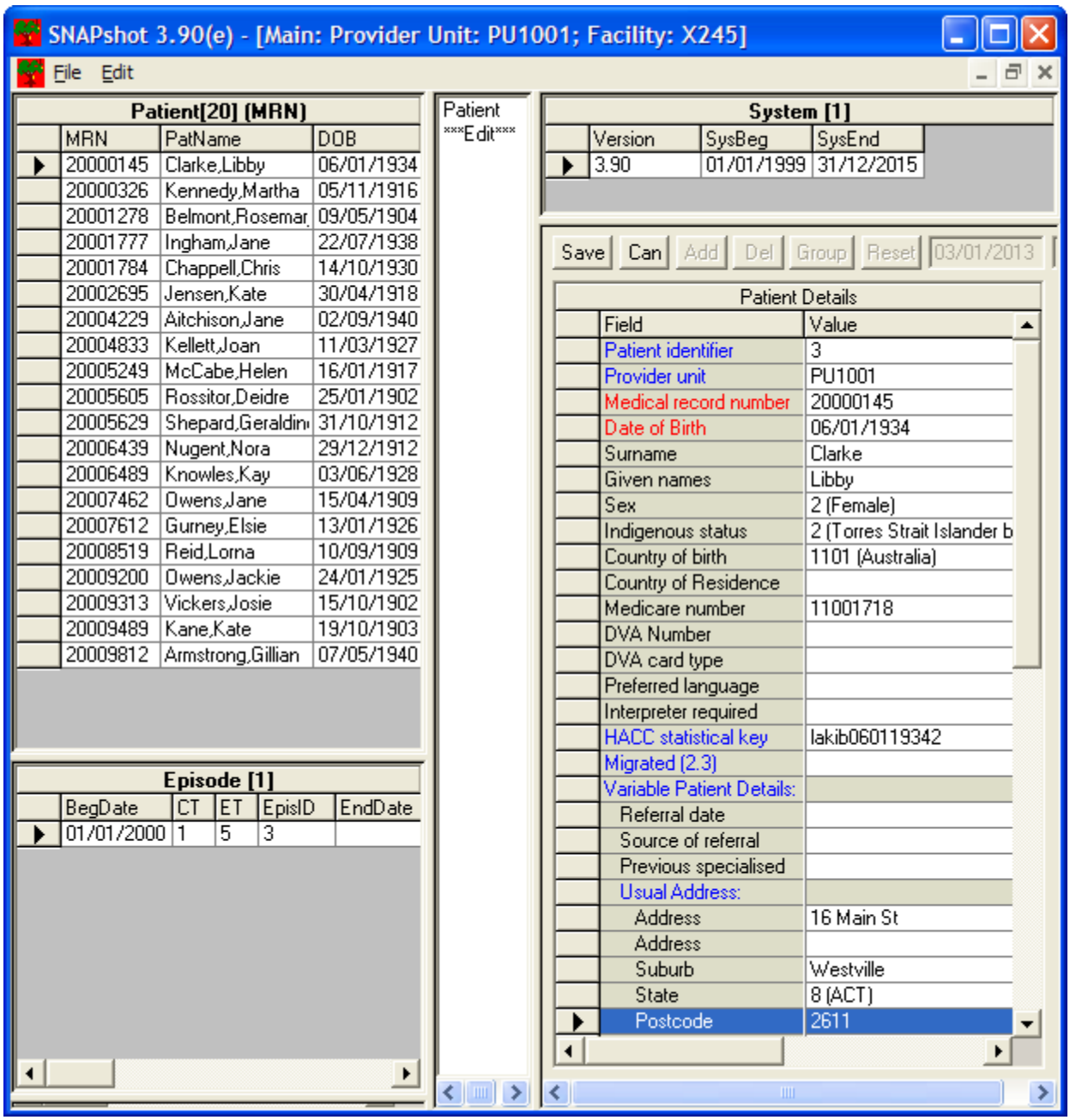
Before adding a new patient it is a good idea to check first to see if they are already in SNAPshot as this will avoid duplicate records. Refer to Appendix 3 for how to search for a patient by MRN or Surname.

Information relating to the Patient unique identification and demographic information is entered here. To add a new Patient record:

1. Select the **'Patient'** data set from the **'Set List'**. The 'Patient Details' screen will now be displayed in the 'Edit View'.
2. Click on **'Add'** — a new Patient Record will be opened in the 'Edit View'.
3. Enter the following 9 data items in the Patient screen:
   - MANDATORY UPI or MRN
   - MANDATORY Family name (used to derive the statistical linkage key)
   - MANDATORY Given name (used to derive the statistical linkage key)
   - MANDATORY Date of birth (used to derive the statistical linkage key)
   - Sex
   - Australian state (under usual address)
   - Australian postcode
   - Indigenous status
   - Country of birth

Once all information on the screen has been entered click **'Save'**

Figure 4 Example of completed PCOC information in the SNAPshot Patient screen



2.3 Entering information into the 'Episode' screen

Information relating to the Patient's episode of care is entered here. To add a new record:

1. Select the **'Episode'** data set from the **'Set List'**. The 'Episode Admin Details' Screen will now be displayed in the 'Edit View'.

2. Click on **'Add'** — a new Episode Record will be opened in the 'Edit View'.

3. Enter the following five data items in the Episode Screen:

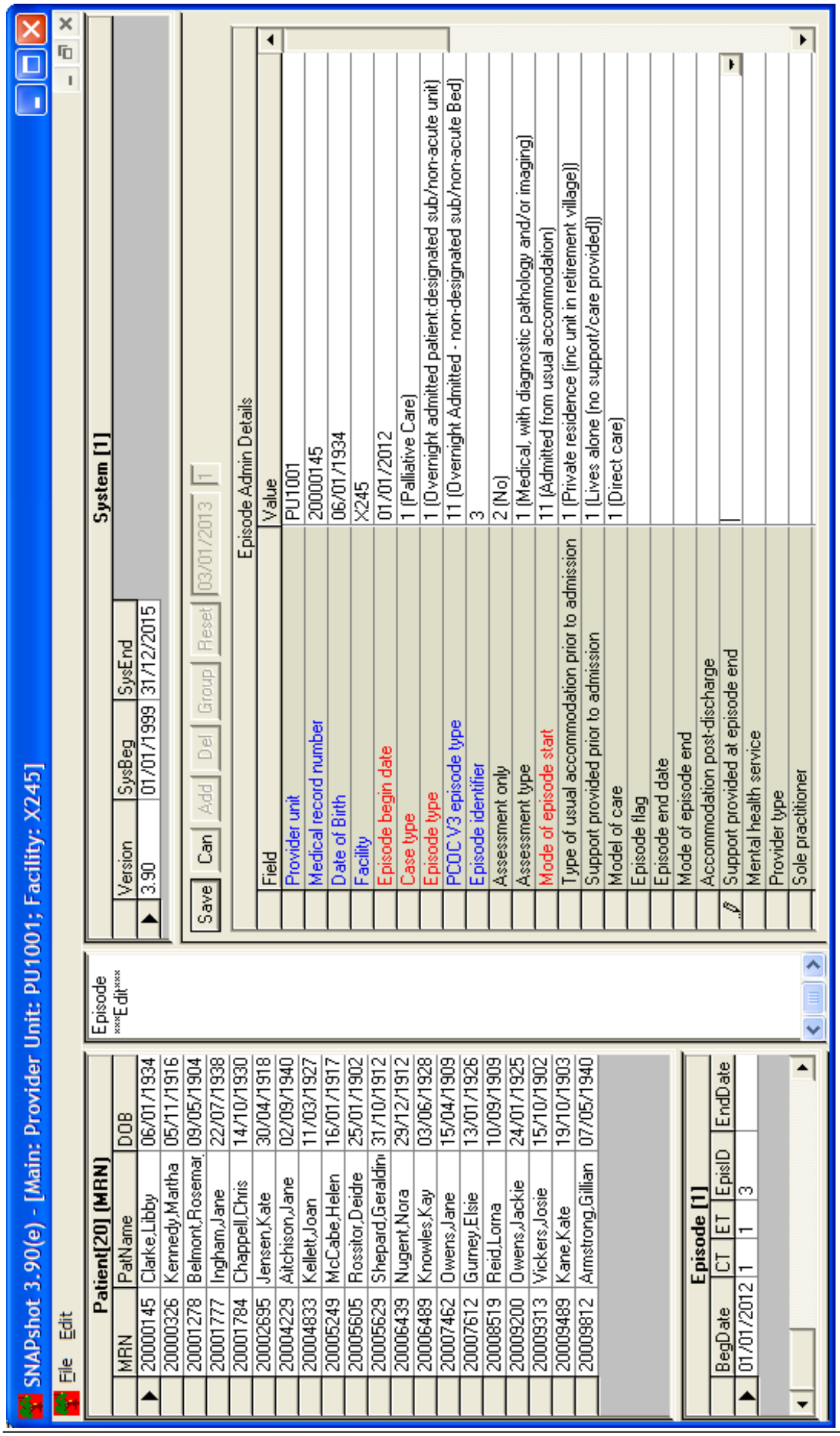
   - MANDATORY Episode begin date
   - MANDATORY Case type
   - MANDATORY Episode Type (NOTE: DO NOT USE CODE 5)
   - MANDATORY Episode Start Mode
   - Accommodation at episode start

After the above data items have been entered: **Press Save and then complete relevant items in the PallCare and PCOC screens.**

Services with multiple teams

If your service has multiple teams, you may need to select the team providing the patient care for this episode in the 'Ward/Team' field. For information on setting up Teams see Appendix 1.

Figure 5 Example of PCOC episode start information in the SNAPshot Episode screen


SNAPshot 3.90(e) - [Main: Provider Unit: PU1001; Facility: X245]
File Edit
Patient[20] [MRN]
MRN PatName DOB
20000145 Clarke,Libby 06/01/1934
20000326 Kennedy,Martha 05/11/1916
20001278 Belmont,Rosemar 09/05/1904
20001777 Ingham,Jane 22/07/1938
20001784 Chappell,Chris 14/10/1930
20002695 Jensen,Kate 30/04/1918
20004229 Aitchison,Jane 02/09/1940
20004833 Kellett,Joan 11/03/1927
20005249 McCabe,Helen 16/01/1917
20005605 Rossitor,Deidre 25/01/1902
20005629 Shepard,Geraldin 31/10/1912
20006439 Nugent,Nora 29/12/1912
20006489 Knowles,Kay 03/06/1928
20007462 Owens,Jane 15/04/1909
20007612 Gurney,Elsie 13/01/1926
20008519 Reid,Lorna 10/09/1909
20009200 Owens,Jackie 24/01/1925
20009313 Vickers,Josie 15/10/1902
20009489 Kane,Kate 19/10/1903
20009812 Armstrong,Gillian 07/05/1940
Episode [1]
BegDate CT ET EpisID EndDate
01/01/2012 1 1 3
Episode
Edit
System [1]
Version SysBeg SysEnd
3.90 01/01/1999 31/12/2015
Save Can Add Del Group Reset 03/01/2013 1
Episode Admin Details
Field Value
Provider unit PU1001
Medical record number 20000145
Date of Birth 06/01/1934
Facility X245
Episode begin date 01/01/2012
Case type 1 [Palliative Care]
Episode type 1 [Overnight admitted patient:designated sub/non-acute unit]
PCOC V3 episode type 11 [Overnight Admitted - non-designated sub/non-acute Bed]
Episode identifier 3
Assessment only 2 [No]
Assessment type 1 [Medical, with diagnostic pathology and/or imaging]
Mode of episode start 11 [Admitted from usual accommodation]
Type of usual accommodation prior to admission 1 [Private residence (inc unit in retirement village)]
Support provided prior to admission 1 [Lives alone (no support/care provided)]
Model of care 1 [Direct care]
Episode flag
Episode end date
Mode of episode end
Accommodation post-discharge
Support provided at episode end
Mental health service
Provider type
Sole practitioner

2.4 What information to enter into the 'PallCare' screen

Information relating to the patient's clinical care are recorded in the PallCare screen.

Having added a new episode by following the steps outlined previously in section 2.3:

1. Select the **PallCare** data set from the **Set List**. The 'Pall Care Phase Details' screen will now be displayed in the 'Edit View'.

2. Click on **Add** — a new PallCare (Phase) Record will be opened in the '**Edit View**'.

3. Enter the following 8 data items in the PallCare screen:

   - MANDATORY Phase begin date
   - MANDATORY Phase (Type)
   - RUG-ADL scores at phase start
   - Symptom Assessment Scores (SAS) at phase start
   - Palliative Care Problem Severity scores (PCPSS) at phase start
   - Australia-Modified Karnofsky Performance Status (AKPS) score at phase start
   - Phase end date
   - Phase end reason

This information is collected on the PCOC Assessment form. The following two examples show you how to enter the collected data.

Figure 6 shows an example of the PCOC Assessment form. Eight columns have been completed by the clinical team, reflecting clinical assessments made each day from admission. However, to capture the information in these 8 columns, in SNAPshot you will only need to create/enter 3 records:

1. A record with:
   Phase = 1 *(Stable)*
   Starting on 05/01/2013 and ending on 07/01/2012
   Phase End Reason = 30 (Phase changed to Deteriorating)

2. A record with:
   Phase = 3 *(Deteriorating)*
   Starting on 07/01/2013 and ending on 10/01/2013
   Phase End Reason = 40 (Phase changed to Terminal)

3. A record with:
   Phase = 4 *(Terminal)*
   Starting on 10/01/2013 and ending on 11/01/2013
   Phase End Reason = 50 (Death)

Figure 6 PCOC Clinical Assessment form – Example 1

St. Example's Palliative Care Service

PCOC palliative care outcomes collaboration

UPI: 20000145
Surname: Doe
First name: John
DOB: 06/01/1934

PCOC Assessment

Instructions: Assess on admission, daily, at phase change and at discharge

Year 2013	Date	05/01	06/01	07/01	08/01	09/01	10/01	11/01	11/01	
	Time	11:34	12:01	10:59	11:02	11:00	11:15	11:03	16:55	
Clinician Rated Score	Phase (1-5)	1	1	3	3	3	4	4	Died	
	RUG ADL (total 4-18)									
	Bed Mobility	3	3	4	4	4	5	5		
	Toileting	3	3	4	4	4	5	5		
	Transfers	3	3	4	4	4	5	5		
	Eating	1	1	2	2	2	3	3		
	Total RUG:	10	10	14	14	14	18	18		
	Problem Severity Score (0-3)									
	Pain	1	1	2	1	1	1	1		
	Other Symptoms	1	1	2	2	2	2	2		
	Psychological/ Spiritual	0	0	1	1	1	1	1		
	Family / Carer	1	1	2	2	3	3	2		
	Australian modified Karnofsky (10-100)	60	60	40	40	30	20	10		
Patient Rated Score	Symptom Assessment Scale (0-10)									
	Difficulty sleeping	3	3	3	3	3	0	0		
	Appetite problems	2	2	2	2	2	0	0		
	Nausea	0	0	0	0	0	0	0		
	Bowel problems	2	2	2	2	2	0	0		
	Breathing problems	0	0	0	0	0	2	2		
	Fatigue	3	3	3	3	3	0	0		
	Pain	2	2	5	3	2	2	2		
	Patient = pt Proxy = pr	pt	pt	pt	pt	pt	pr	pr		
Reason for Phase End (10-70)										
Staff Initials:										

PCOC ASSESSMENT

November 2012

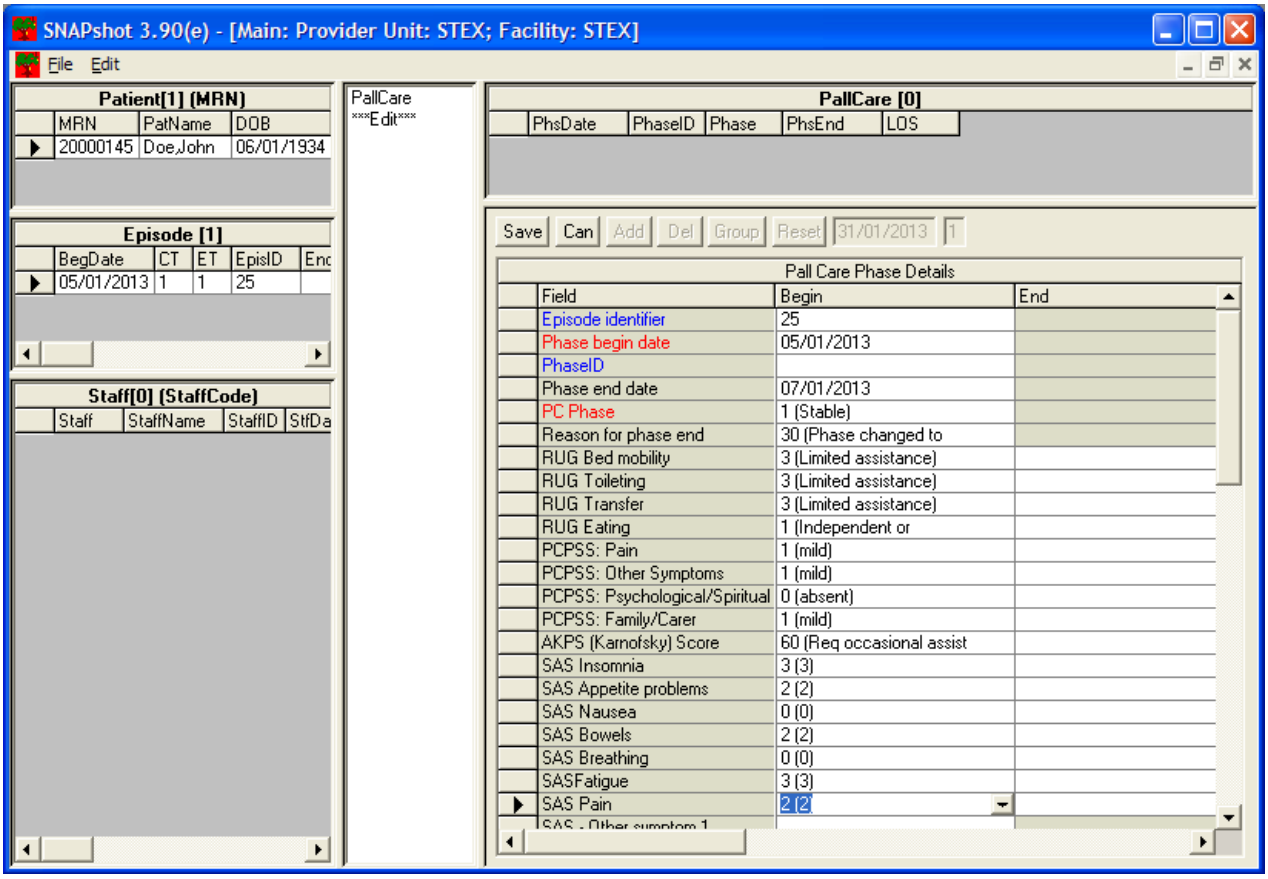
Having already entered the necessary information into the Patient, Episode and PCOC screens, highlight the PallCare entry from the white list in the middle of the screen and click on **Add.**

To create the first record, enter:

05/01/2013 into the *Phase begin date* field
07/01/2013 into the *Phase end date* field
1 (Stable) into the *PC Phase* field
30 (Phase changed to Deteriorating) into the *Reason for phase end* field

Enter the RUG, PCPSS (Problem Severity), Karnofsky and SAS assessments recorded on the form in the column under 05/01.

The screen should look like:


SNAPshot 3.90(e) - [Main: Provider Unit: STEX; Facility: STEX]
File Edit
Patient[1] (MRN)
MRN PatName DOB
20000145 Doe,John 06/01/1934
Episode [1]
BegDate CT ET EpisID
05/01/2013 1 1 25
Staff[0] (StaffCode)
Staff StaffName StaffID
PallCare
Edit
PallCare [0]
PhsDate PhaseID Phase PhsEnd LOS
Save Can Add Del Group Reset 31/01/2013 1
Pall Care Phase Details
Field Begin End
Episode identifier 25
Phase begin date 05/01/2013
PhaseID
Phase end date 07/01/2013
PC Phase 1 (Stable)
Reason for phase end 30 (Phase changed to
RUG Bed mobility 3 (Limited assistance)
RUG Toileting 3 (Limited assistance)
RUG Transfer 3 (Limited assistance)
RUG Eating 1 (Independent or
PCPSS: Pain 1 (mild)
PCPSS: Other Symptoms 1 (mild)
PCPSS: Psychological/Spiritual 0 (absent)
PCPSS: Family/Carer 1 (mild)
AKPS (Karnofsky) Score 60 (Req occasional assist
SAS Insomnia 3 (3)
SAS Appetite problems 2 (2)
SAS Nausea 0 (0)
SAS Bowels 2 (2)
SAS Breathing 0 (0)
SASFatigue 3 (3)
SAS Pain 2 (2

Click **Save.**

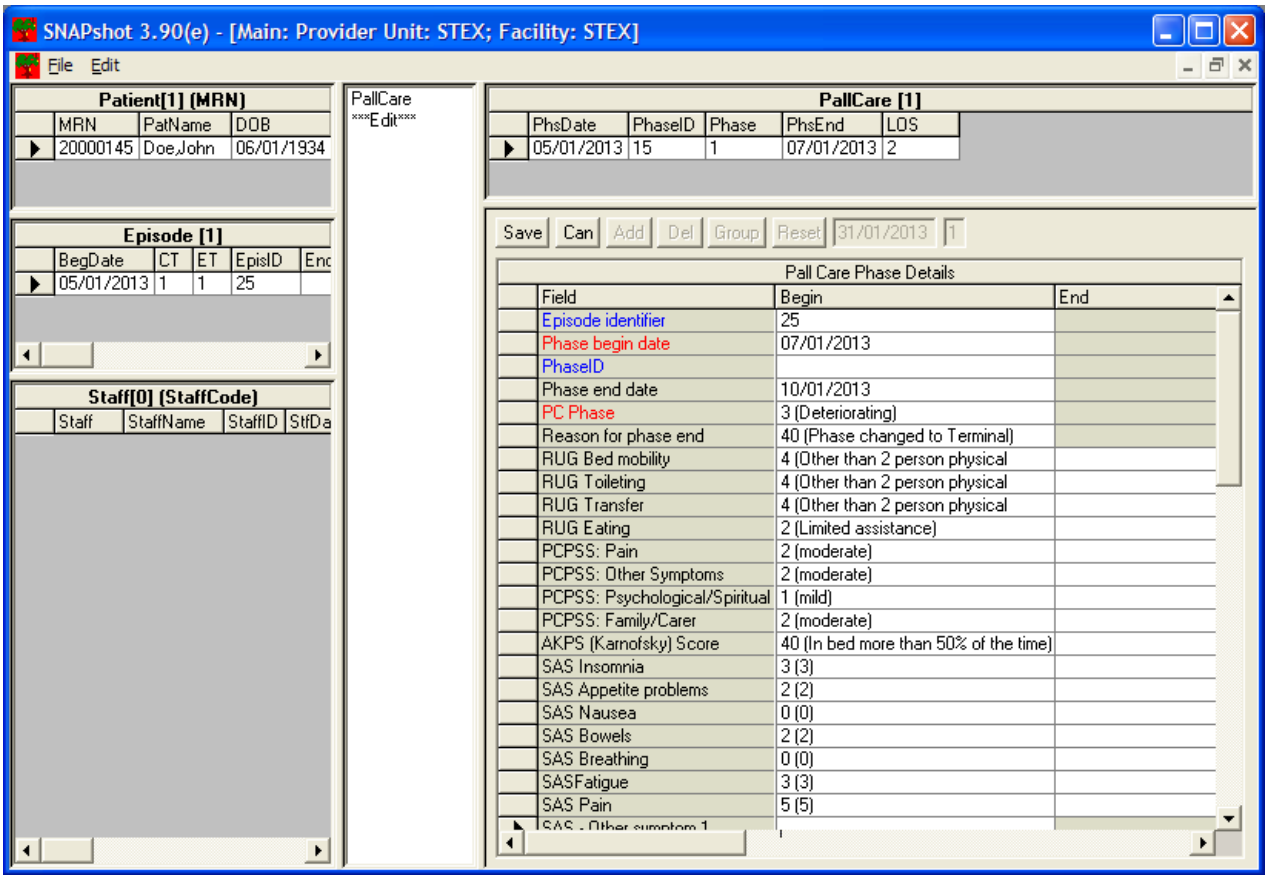
To create the second record:

Click **Add** and then enter:

07/01/2013 into the *Phase begin date* field
10/01/2013 into the *Phase end date* field
3 (Deteriorating) into the *PC Phase* field
40 (Phase changed to Terminal) into the *Reason for phase end* field

Enter the RUG, PCPSS (Problem Severity), Karnofsky and SAS assessments recorded on the form in the column under 07/01.

The screen should look like:


SNAPshot 3.90(e) - [Main: Provider Unit: STEX; Facility: STEX]
File Edit
Patient[1] (MRN)
MRN PatName DOB
20000145 Doe,John 06/01/1934
Episode [1]
BegDate CT ET EpisID
05/01/2013 1 1 25
Staff[0] (StaffCode)
Staff StaffName StaffID
PallCare
Edit
PallCare [1]
PhsDate PhaseID Phase PhsEnd LOS
05/01/2013 15 1 07/01/2013 2
Save Can Add Del Group Reset 31/01/2013 1
Pall Care Phase Details
Field Begin End
Episode identifier 25
Phase begin date 07/01/2013
PhaseID
Phase end date 10/01/2013
PC Phase 3 (Deteriorating)
Reason for phase end 40 (Phase changed to Terminal)
RUG Bed mobility 4 (Other than 2 person physical
RUG Toileting 4 (Other than 2 person physical
RUG Transfer 4 (Other than 2 person physical
RUG Eating 2 (Limited assistance)
PCPSS: Pain 2 (moderate)
PCPSS: Other Symptoms 2 (moderate)
PCPSS: Psychological/Spiritual 1 (mild)
PCPSS: Family/Carer 2 (moderate)
AKPS (Karnofsky) Score 40 (In bed more than 50% of the time)
SAS Insomnia 3 (3)
SAS Appetite problems 2 (2)
SAS Nausea 0 (0)
SAS Bowels 2 (2)
SAS Breathing 0 (0)
SASFatigue 3 (3)
SAS Pain 5 (5)

Click **Save.**

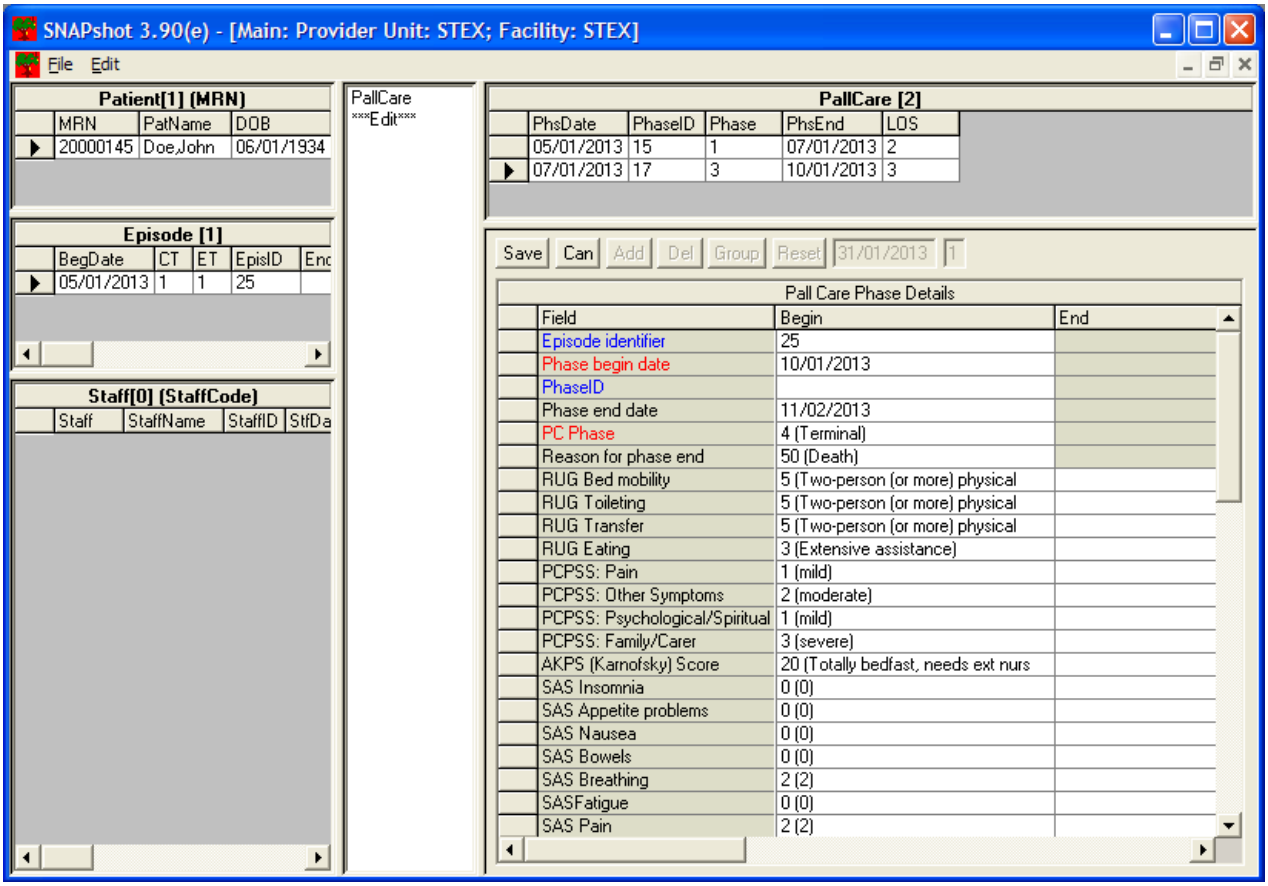
To create the third and final record:

Click **Add** and enter:

10/01/2013 into the *Phase begin date* field
11/01/2013 into the *Phase end date* field
4 (Terminal) into the *PC Phase* field
50 (Death) into the *Reason for phase end* field

Enter the RUG, PCPSS (Problem Severity), Karnofsky and SAS assessments recorded on the form in the column under 10/01.

The screen should look like:


SNAPshot 3.90(e) - [Main: Provider Unit: STEX; Facility: STEX]
File Edit
Patient[1] (MRN)
MRN PatName DOB
20000145 Doe,John 06/01/1934
Episode [1]
BegDate CT ET EpisID
05/01/2013 1 1 25
Staff[0] (StaffCode)
Staff StaffName StaffID
PallCare
Edit
PallCare [2]
PhsDate PhaseID Phase PhsEnd LOS
05/01/2013 15 1 07/01/2013 2
07/01/2013 17 3 10/01/2013 3
Save Can Add Del Group Reset 31/01/2013
Pall Care Phase Details
Field Begin End
Episode identifier 25
Phase begin date 10/01/2013
PhaseID
Phase end date 11/02/2013
PC Phase 4 (Terminal)
Reason for phase end 50 (Death)
RUG Bed mobility 5 (Two-person (or more) physical
RUG Toileting 5 (Two-person (or more) physical
RUG Transfer 5 (Two-person (or more) physical
RUG Eating 3 (Extensive assistance)
PCPSS: Pain 1 (mild)
PCPSS: Other Symptoms 2 (moderate)
PCPSS: Psychological/Spiritual 1 (mild)
PCPSS: Family/Carer 3 (severe)
AKPS (Karnofsky) Score 20 (Totally bedfast, needs ext nurs
SAS Insomnia 0 (0)
SAS Appetite problems 0 (0)
SAS Nausea 0 (0)
SAS Bowels 0 (0)
SAS Breathing 2 (2)
SASFatigue 0 (0)
SAS Pain 2 (2)

Click **Save**. This completes the data entry process for this PCOC Assessment form.

Figure 7 shows a second example of the PCOC Assessment form. Four columns have been completed by the clinical team, reflecting clinical assessments made each day from admission. However, to capture the information in these 4 columns, in SNAPshot you will only need to create/enter 2 records:

1. A record with:
   Phase = 2 *(Unstable)*
   Starting on 11/02/2013 and ending on 13/02/2012
   Phase End Reason = 10 *(Phase changed to Stable)*

2. A record with:
   Phase = 1 *(Stable)*
   Starting on 13/02/2013 and ending on 14/02/2013
   Phase End Reason = 70 *(Discharge)*

Figure 7 PCOC Clinical Assessment form – Example 2

St. Example's Palliative Care Service	PCOC palliative care outcomes collaboration	**UPI:** 20000146 **Surname:** Doe **First name:** Jane **DOB:** 08/04/1931

PCOC Assessment

Instructions: Assess on admission, daily, at phase change and at discharge

Year 2013	Date	11/02	12/02	13/02	14/02					
	Time	11:34	12:01	10:59	11:02					
Clinician Rated Score	Phase (1-5)	2	2	1	D/C					
	RUG ADL (total 4-18)									
	Bed Mobility	3	3	3	3					
	Toileting	3	3	3	3					
	Transfers	3	3	3	3					
	Eating	1	1	1	1					
	Total RUG:	10	10	10	10					
	Problem Severity Score (0-3)									
	Pain	3	2	1	1					
	Other Symptoms	3	2	1	1					
	Psychological/ Spiritual	0	0	0	0					
	Family / Carer	2	1	1	1					
	Australian modified Karnofsky (10-100)	50	50	50	50					
Patient Rated Score	Symptom Assessment Scale (0-10)									
	Difficulty sleeping	5	4	4	4					
	Appetite problems	6	5	5	4					
	Nausea	8	5	3	3					
	Bowel problems	2	2	1	1					
	Breathing problems	0	0	0	0					
	Fatigue	8	8	5	4					
	Pain	8	5	2	2					
	Patient = pt Proxy = pr	pt	pt	pt	pt					
Reason for Phase End (10-70)										
Staff Initials:										

PCOC ASSESSMENT

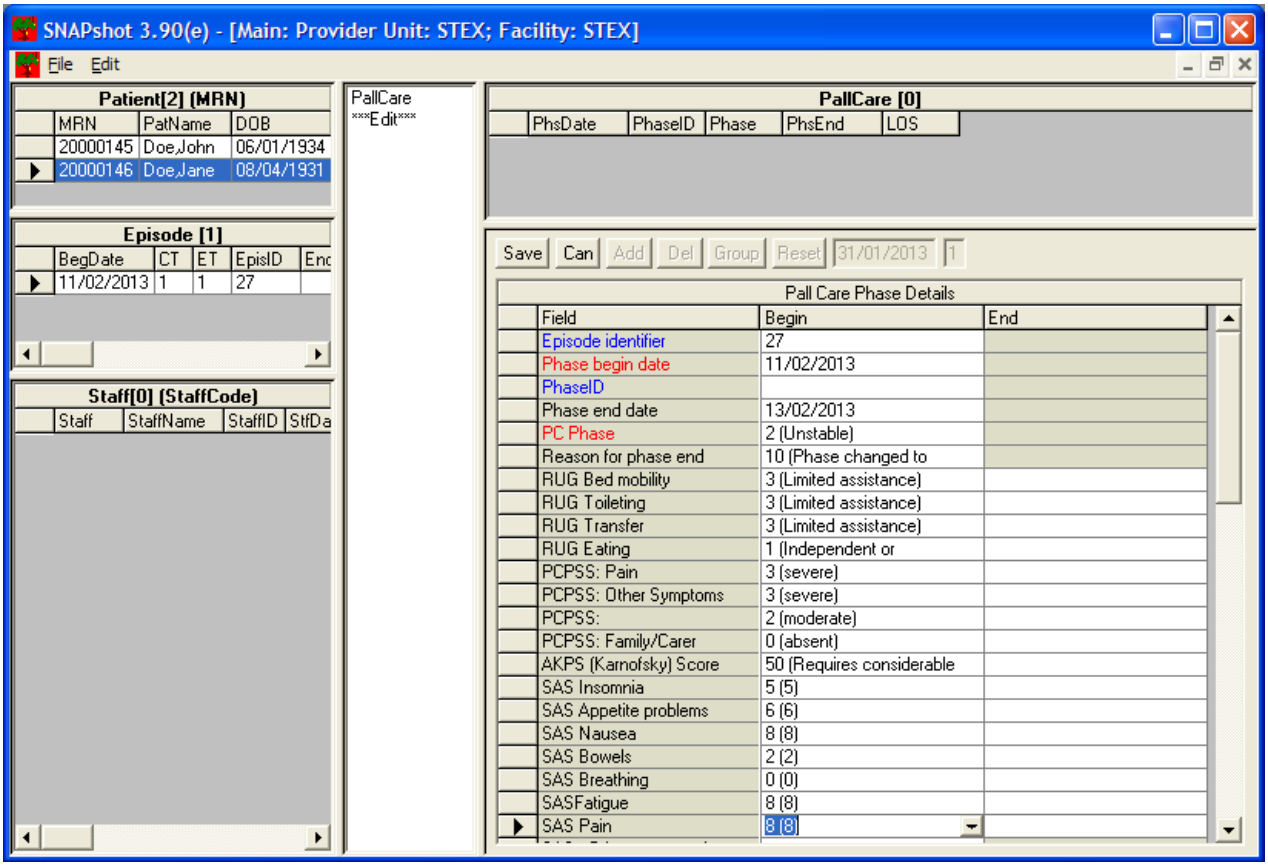
November 2012

To create the first record, enter:

11/02/2013 into the *Phase begin date* field
13/02/2013 into the *Phase end date* field
2 (Unstable) into the *PC Phase* field
10 (Phase changed to Stable) into the *Reason for phase end* field

Enter the RUG, PCPSS (Problem Severity), Karnofsky and SAS assessments recorded on the form in the column under 11/02.

The screen should look like:



Click **Save.**

To create the second record:

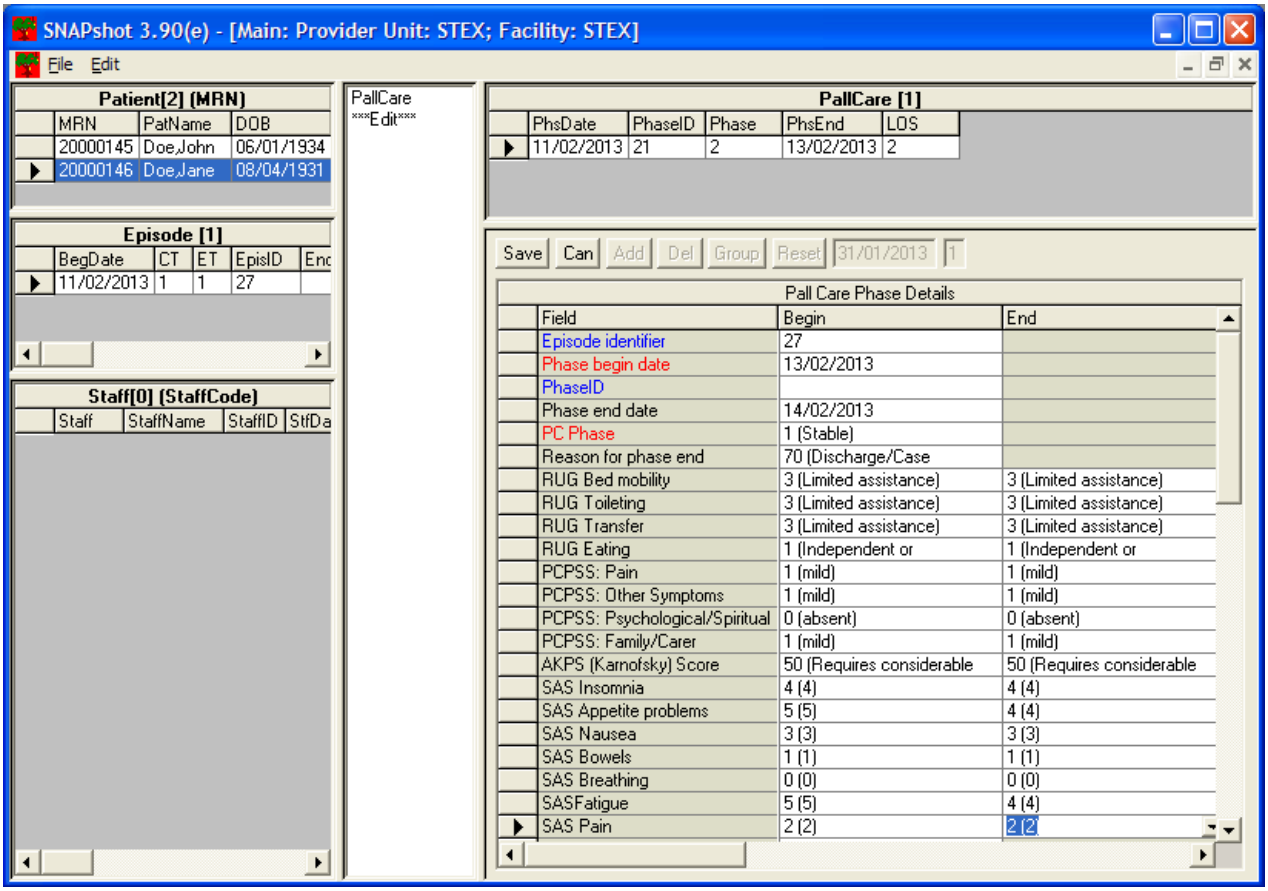
Click **Add** and then enter:

13/02/2013 into the *Phase begin date* field
14/02/2013 into the *Phase end date* field
1 (Stable) into the *PC Phase* field
70 (Discharged) into the *Reason for phase end* field

As before, enter the RUG, PCPSS (Problem Severity), Karnofsky and SAS assessments recorded on the form in the column under 13/02.

As the patient has been discharged on 14/02, we also need to enter the scores recorded under 14/02. We enter these scores in the End column.

The screen should look like:


SNAPshot 3.90(e) - [Main: Provider Unit: STEX; Facility: STEX]
File Edit
Patient[2] (MRN)
MRN PatName DOB
20000145 Doe,John 06/01/1934
20000146 Doe,Jane 08/04/1931
Episode [1]
BegDate CT ET EpisID Enc
11/02/2013 1 1 27
Staff[0] (StaffCode)
Staff StaffName StaffID StfDa
PallCare
Edit
PallCare [1]
PhsDate PhaseID Phase PhsEnd LOS
11/02/2013 21 2 13/02/2013 2
Save Can Add Del Group Reset 31/01/2013 1
Pall Care Phase Details
Field Begin End
Episode identifier 27
Phase begin date 13/02/2013
PhaseID
Phase end date 14/02/2013
PC Phase 1 (Stable)
Reason for phase end 70 (Discharge/Case
RUG Bed mobility 3 (Limited assistance) 3 (Limited assistance)
RUG Toileting 3 (Limited assistance) 3 (Limited assistance)
RUG Transfer 3 (Limited assistance) 3 (Limited assistance)
RUG Eating 1 (Independent or 1 (Independent or
PCPSS: Pain 1 (mild) 1 (mild)
PCPSS: Other Symptoms 1 (mild) 1 (mild)
PCPSS: Psychological/Spiritual 0 (absent) 0 (absent)
PCPSS: Family/Carer 1 (mild) 1 (mild)
AKPS (Karnofsky) Score 50 (Requires considerable 50 (Requires considerable
SAS Insomnia 4 (4) 4 (4)
SAS Appetite problems 5 (5) 4 (4)
SAS Nausea 3 (3) 3 (3)
SAS Bowels 1 (1) 1 (1)
SAS Breathing 0 (0) 0 (0)
SASFatigue 5 (5) 4 (4)
SAS Pain 2 (2) 2 (2

Notice that the clinical assessments have been completed in both the Begin and End columns.

Click **Save**. This completes the data entry process for this PCOC Assessment form.

If the clinical assessments have not been recorded on the date of discharge (discharge includes transfer to hospital in the community setting) then enter the relevant **'Not assessed'** code in the End column.

2.5 Entering information into the 'PCOC' screen

It is compulsory to create a PCOC dataset record before ending palliative care episodes. SNAPshot will NOT allow you to end an episode of care in the Episode screen if the PCOC screen has not been completed.

The remaining data items in the Version 3 PCOC dataset are entered into the 'PCOC' screen. After adding a new Episode record together with subsequent PallCare data, do the following:

1. Select the **'PCOC'** data set from the **'Set List'**. The 'PCOC' Screen will now be displayed in the 'Edit View'.

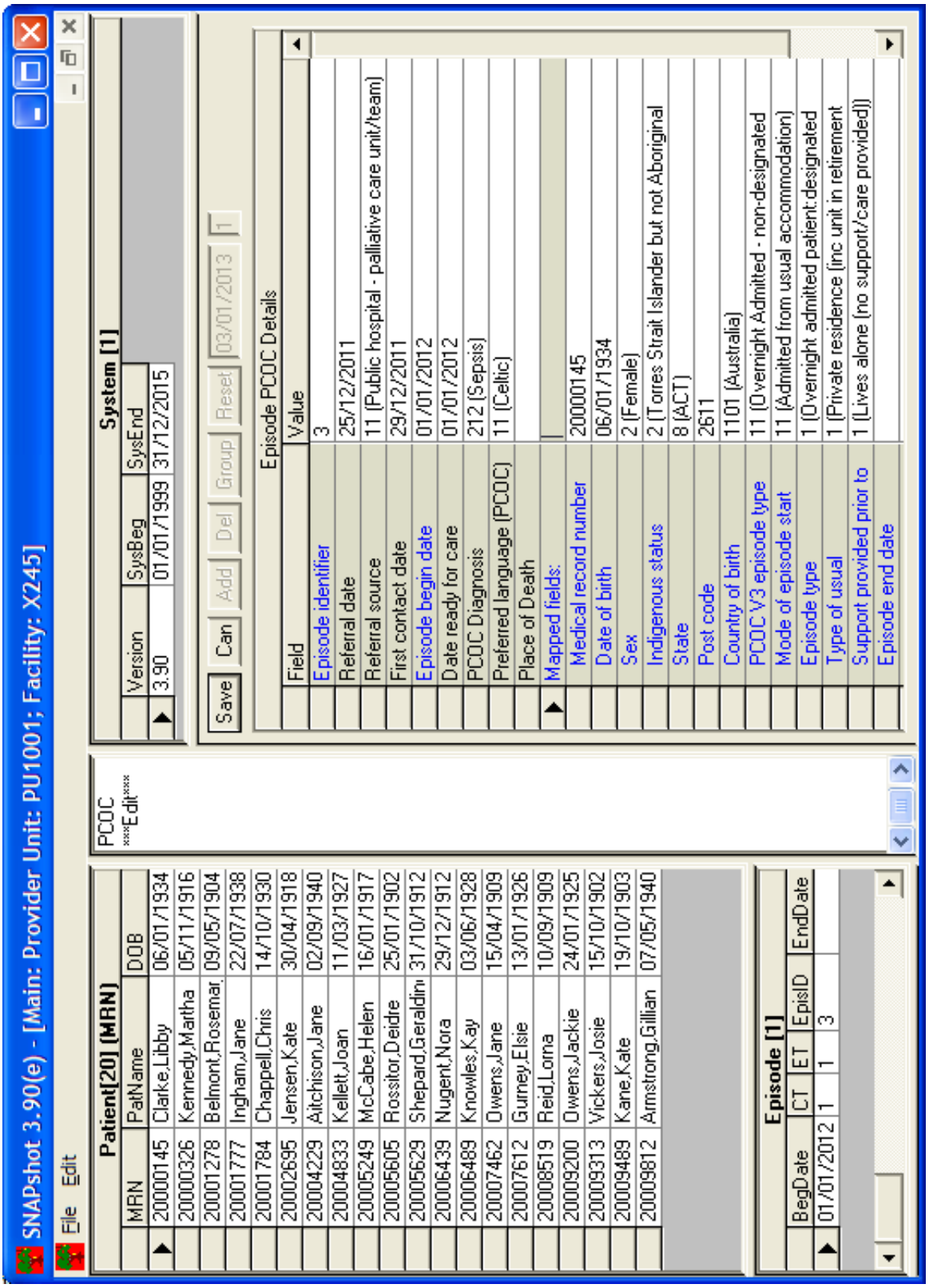
2. Click on **'Add'** — a new PCOC record will be opened in the 'Edit View'.

3. Enter the following seven data items in the 'PCOC' screen

   - Referral source
   - Referral date
   - First contact date
   - Date ready for care
   - PCOC Diagnosis
   - Preferred language (PCOC)
   - Place of death (only completed if episode end mode is: death)

Once all information on the screen has been entered click **'Save'**

Figure 8 Example of completed PCOC information in the SNAPshot PCOC screen


SNAPshot 3.90(e) - [Main: Provider Unit: PU1001; Facility: X245]
File Edit
Patient[20] (MRN)
MRN PatName DOB
20000145 Clarke,Libby 06/01/1934
20000326 Kennedy,Martha 05/11/1916
20001278 Belmont,Rosemar 09/05/1904
20001777 Ingham,Jane 22/07/1938
20001784 Chappell,Chris 14/10/1930
20002695 Jensen,Kate 30/04/1918
20004229 Aitchison,Jane 02/09/1940
20004833 Kellett,Joan 11/03/1927
20005249 McCabe,Helen 16/01/1917
20005605 Rossitor,Deidre 25/01/1902
20005629 Shepard,Geraldin 31/10/1912
20006439 Nugent,Nora 29/12/1912
20006489 Knowles,Kay 03/06/1928
20007462 Owens,Jane 15/04/1909
20007612 Gurney,Elsie 13/01/1926
20008519 Reid,Lorna 10/09/1909
20009200 Owens,Jackie 24/01/1925
20009313 Vickers,Josie 15/10/1902
20009489 Kane,Kate 19/10/1903
20009812 Armstrong,Gillian 07/05/1940
Episode [1]
BegDate CT ET EpisID EndDate
01/01/2012 1 1 3
PCOC
Edit
System [1]
Version SysBeg SysEnd
3.90 01/01/1999 31/12/2015
Save Can Add Del Group Reset 03/01/2013 1
Episode PCOC Details
Field Value
Episode identifier 3
Referral date 25/12/2011
Referral source 11 (Public hospital - palliative care unit/team)
First contact date 29/12/2011
Episode begin date 01/01/2012
Date ready for care 01/01/2012
PCOC Diagnosis 212 (Sepsis)
Preferred language (PCOC) 11 (Celtic)
Place of Death
Mapped fields:
Medical record number 20000145
Date of birth 06/01/1934
Sex 2 (Female)
Indigenous status 2 (Torres Strait Islander but not Aboriginal
State 8 (ACT)
Post code 2611
Country of birth 1101 (Australia)
PCOC V3 episode type 11 (Overnight Admitted - non-designated
Mode of episode start 11 (Admitted from usual accommodation)
Episode type 1 (Overnight admitted patient:designated
Type of usual 1 (Private residence (inc unit in retirement
Support provided prior to 1 (Lives alone (no support/care provided))
Episode end date

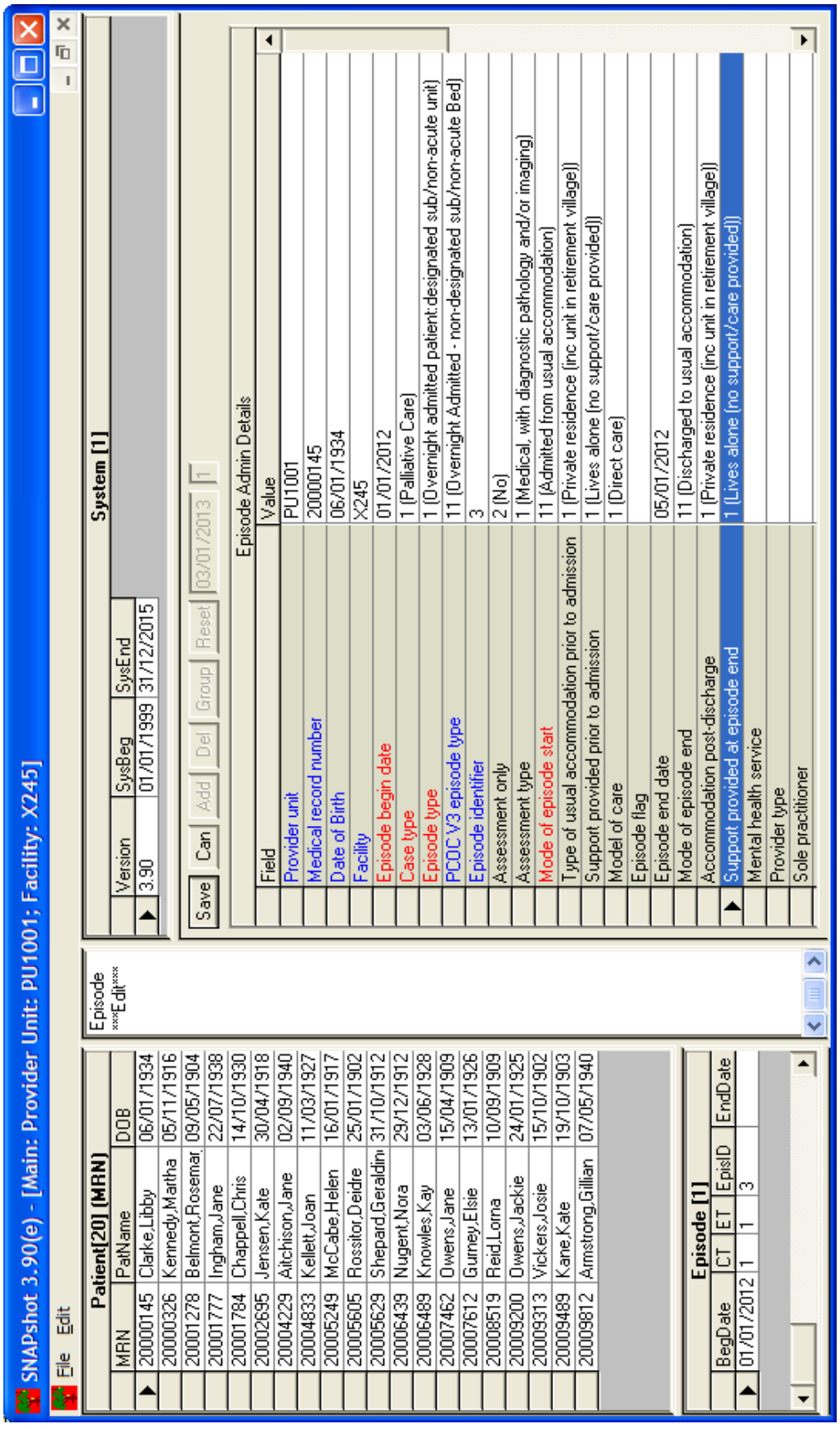
2.6 Entering information for an episode that has ended (closed episode)

Once a patient's episode of palliative care has ended, the episode end information must be completed in the 'Episode' screen. To do this, find the relevant episode record and complete:

- Episode end date
- Mode of episode end
- Accommodation post-discharge (Accommodation at episode end)

Figure 8 shows an example of a closed episode in the SNAPshot episode screen.

Figure 9 Example of completed information in the SNAPshot Episode screen

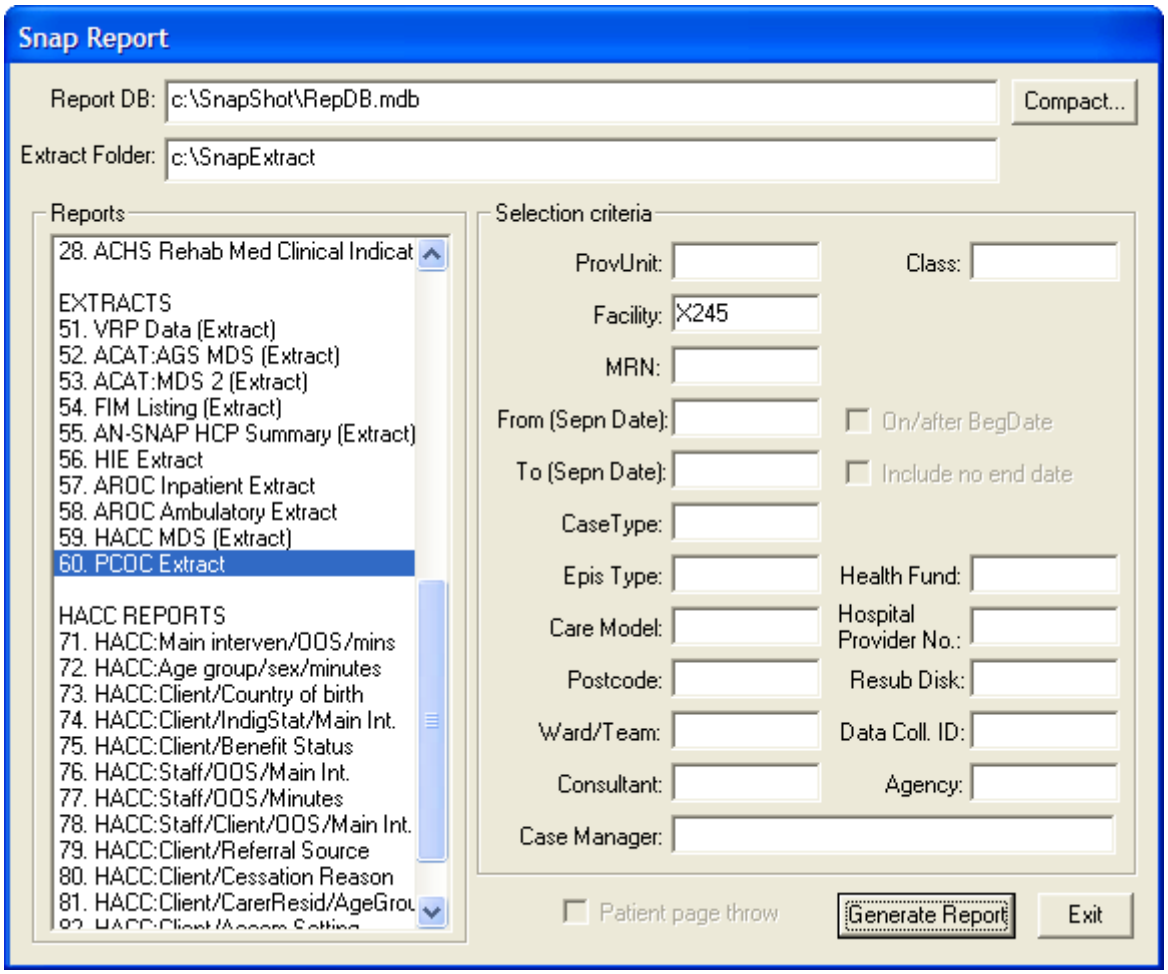

SNAPshot 3.90(e) - [Main: Provider Unit: PU1001; Facility: X245]
File Edit
Patient[20] (MRN)
MRN PatName DOB
20000145 Clarke,Libby 06/01/1934
20000326 Kennedy,Martha 05/11/1916
20001278 Belmont,Rosemar 09/05/1904
20001777 Ingham,Jane 22/07/1938
20001784 Chappell,Chris 14/10/1930
20002695 Jensen,Kate 30/04/1918
20004229 Aitchison,Jane 02/09/1940
20004833 Kellett,Joan 11/03/1927
20005249 McCabe,Helen 16/01/1917
20005605 Rossitor,Deidre 25/01/1902
20005629 Shepard,Geraldin 31/10/1912
20006439 Nugent,Nora 29/12/1912
20006489 Knowles,Kay 03/06/1928
20007462 Owens,Jane 15/04/1909
20007612 Gurney,Elsie 13/01/1926
20008519 Reid,Lorna 10/09/1909
20009200 Owens,Jackie 24/01/1925
20009313 Vickers,Josie 15/10/1902
20009489 Kane,Kate 19/10/1903
20009812 Armstrong,Gillian 07/05/1940
Episode [1]
BegDate CT ET EpisID EndDate
01/01/2012 1 1 3
Episode ****Edit****
System [1]
Version SysBeg SysEnd
3.90 01/01/1999 31/12/2015
Save Can Add Del Group Reset 03/01/2013 1
Episode Admin Details
Field Value
Provider unit PU1001
Medical record number 20000145
Date of Birth 06/01/1934
Facility X245
Episode begin date 01/01/2012
Case type 1 [Palliative Care]
Episode type 1 [Overnight admitted patient:designated sub/non-acute unit]
PCOC V3 episode type 11 [Overnight Admitted - non-designated sub/non-acute Bed]
Episode identifier 3
Assessment only 2 [No]
Assessment type 1 [Medical, with diagnostic pathology and/or imaging]
Mode of episode start 11 [Admitted from usual accommodation]
Type of usual accommodation prior to admission 1 [Private residence (inc unit in retirement village)]
Support provided prior to admission 1 [Lives alone (no support/care provided)]
Model of care 1 [Direct care]
Episode flag
Episode end date 05/01/2012
Mode of episode end 11 [Discharged to usual accommodation]
Accommodation post-discharge 1 [Private residence (inc unit in retirement village)]
Support provided at episode end 1 [Lives alone (no support/care provided)]
Mental health service
Provider type
Sole practitioner

3 Generating the PCOC Extract

To create the PCOC data extracts:

Press **Shift+ F8** whilst positioned on any of the data lists in SNAPshot. This will bring up the 'Snap Report' window:

Figure 10 Example of the Snap Report window



In the *Reports* section, scroll down and select **60. PCOC Extract** and in the *Selection criteria* section, enter your Facility ID next to Facility.

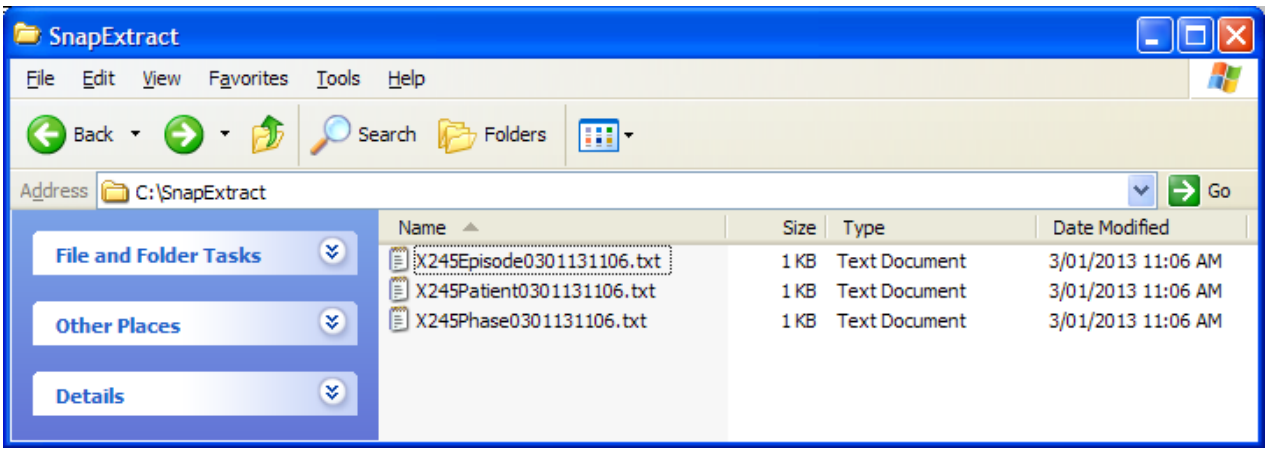
Click on the **Generate Report** button at the bottom, click **OK** on the resulting screen and then click on **Exit** on the *Snap Report screen.*

To find the extracts you need to navigate to the **SnapExtract** folder on your **C:** drive. You will see three files, in the format:

XXXXPatientDDMMYYYYHHMM.txt
XXXXEpisodeDDMMYYYYHHMM.txt
XXXXPhaseDDMMYYYYHHMM.txt

DDMMYYYYHHMM will be the current date and time and XXXX will be replaced by the Facility ID you entered previously.

Figure 11 Example of the SnapExtract folder


SnapExtract
File Edit View Favorites Tools Help
Back Search Folders
Address C:\SnapExtract
Go
File and Folder Tasks
Other Places
Details
Name Size Type Date Modified
X245Episode0301131106.txt 1 KB Text Document 3/01/2013 11:06 AM
X245Patient0301131106.txt 1 KB Text Document 3/01/2013 11:06 AM
X245Phase0301131106.txt 1 KB Text Document 3/01/2013 11:06 AM

These three files can now be emailed to PCOC at pcoc@uow.edu.au and cc'ed to you PCOC Quality Improvement Facilitator – note that the extract contains 'MRN' and 'date of birth', but does not include any other identifying data items.

These extracts will undergo a quality 'check', and you will receive a PCOC Data Quality report, identifying data entry errors and missing data. Once these have been addressed in SNAPshot, you can generate a new set of extracts and re-submit to PCOC by repeating the process described.

4 Frequently Asked Questions

4.1 SNAPshot is asking me for a password – what is it?

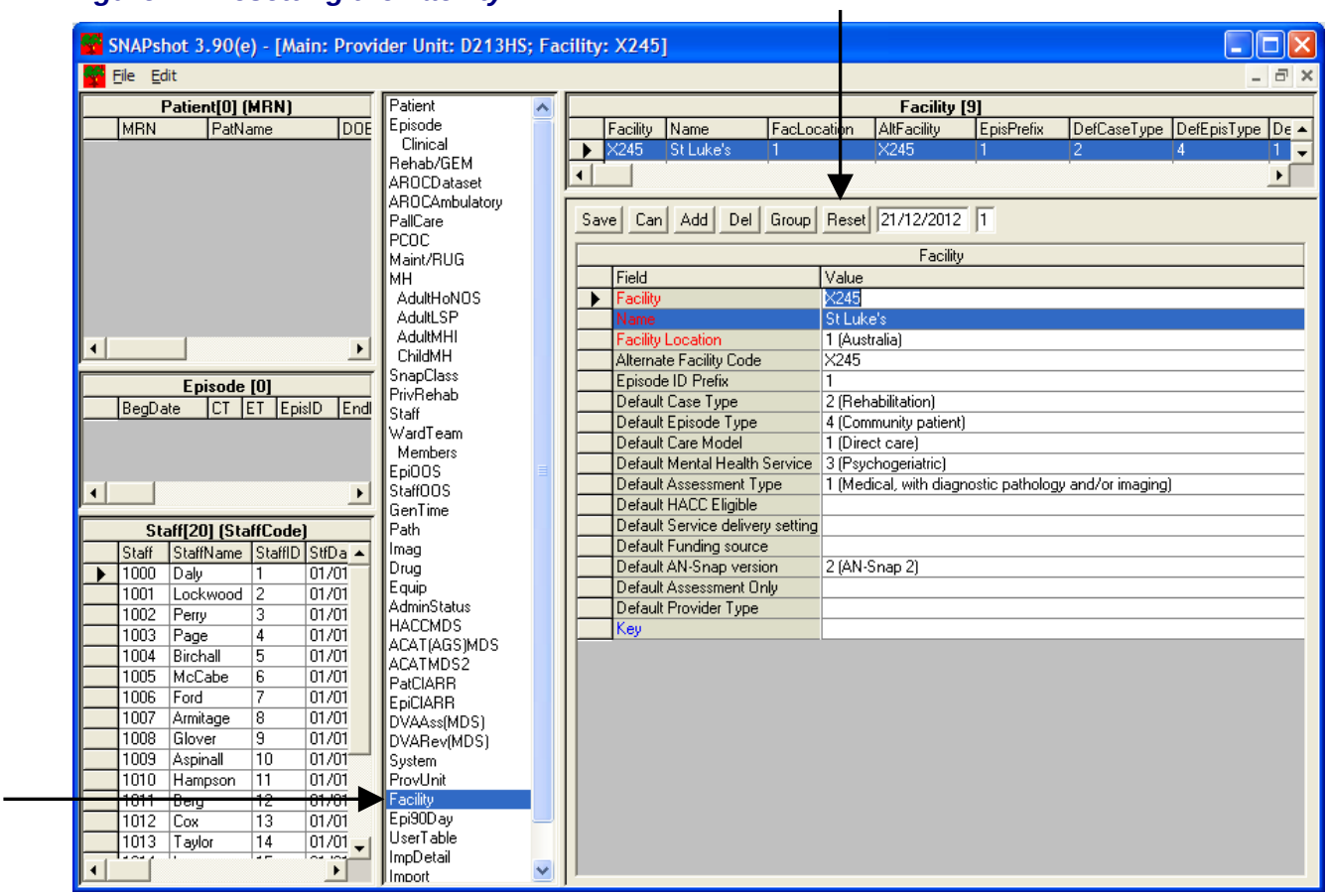
The default password is "**admink**"

4.2 My patients have all disappeared – how do I get them back?

If, on opening up the main screen and logging on, you do not see any data, you will need to reset which Facility and Provider unit SNAPshot should be focusing on. To do this, simply highlight Facility in the Set List and then click on Reset (this button can be found in the middle of the right hand window), refer to Figure 12, now highlight ProvUnit in the set list and click Reset again, refer to Figure 13. At this point your data should 'magically' reappear (see Figure 14).

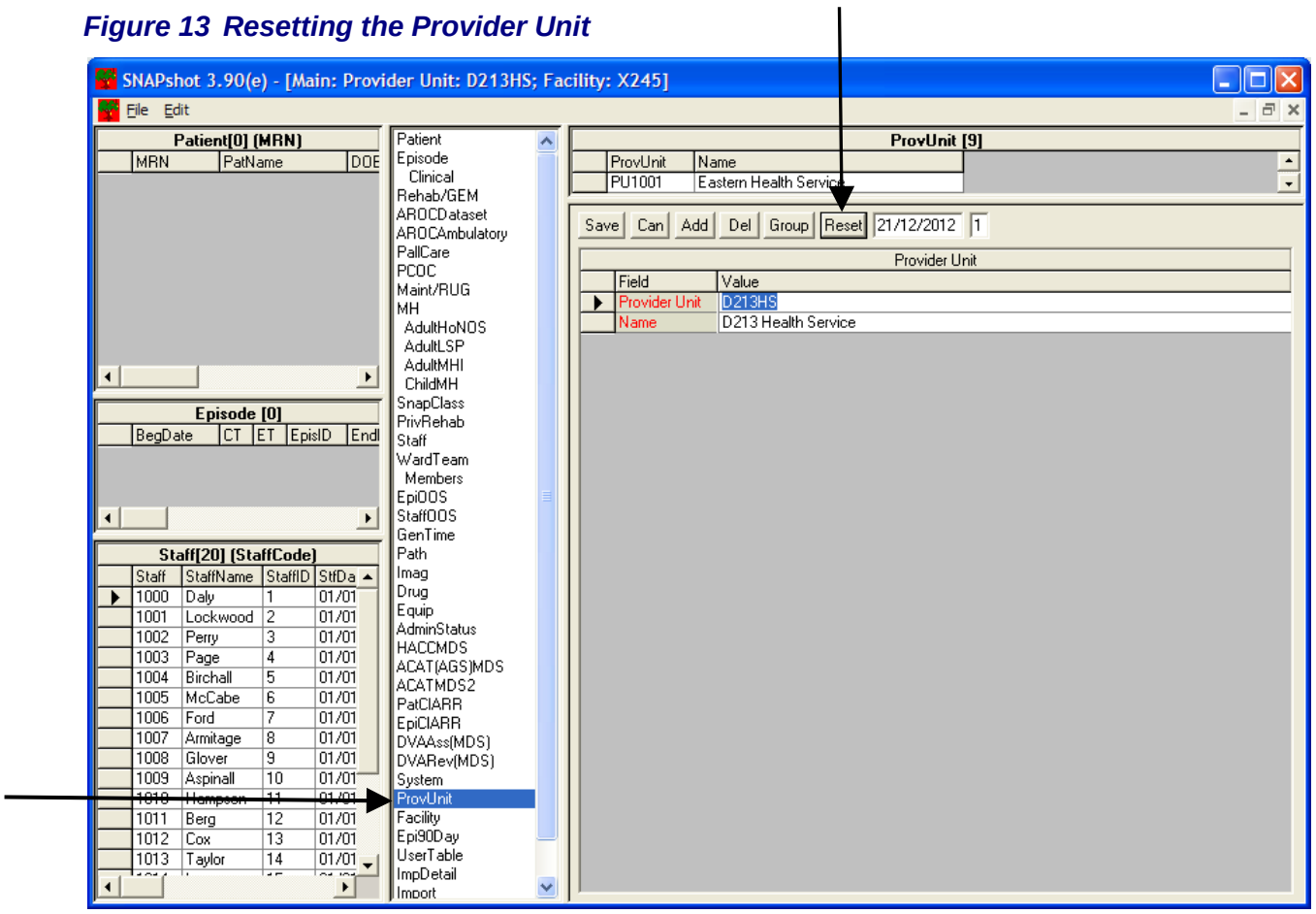
If you have more than one Facility or Provider Unit you will need to also select the appropriate Facility/ProvUnit in the multi list (top right hand window)

Figure 12 Resetting the Facility



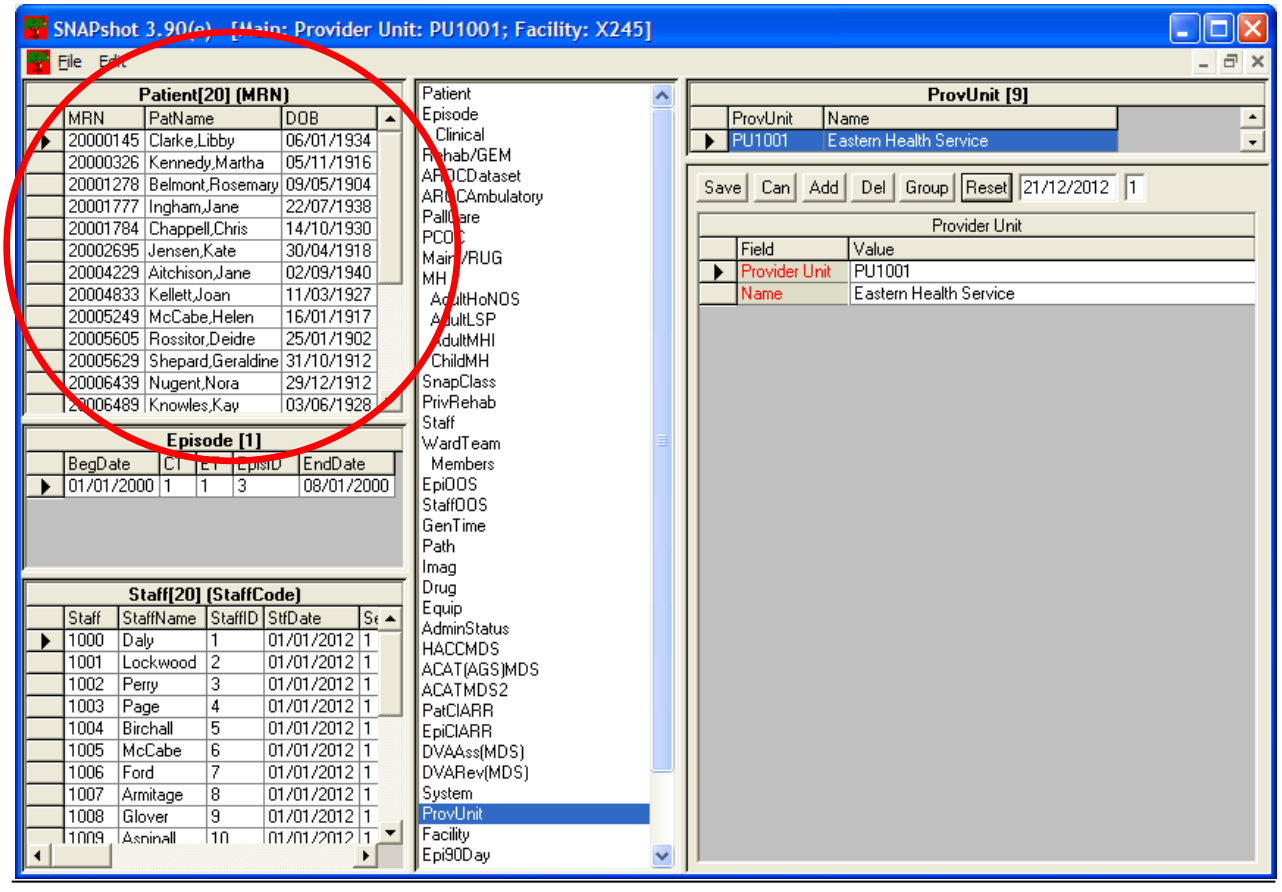
Once the Facility has been reset, the Facility wide data items will be visible.

Figure 13 Resetting the Provider Unit



Once the Provider Unit has been reset the data sets under that Provider Unit will be visible.

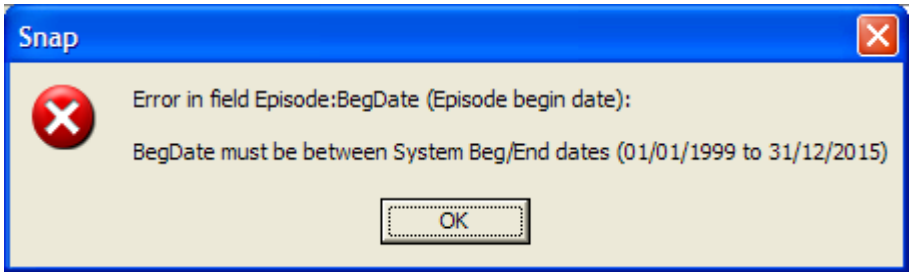
Figure 14 The SNAPshot Main Screen after resetting the Facility and Provider Unit



4.3 SNAPshot is showing me a system date error – how do I fix it?

Figure 15 shows an example of the SNAPshot system date error screen. This error appears when a record being entered starts outside of the data collection defined in SNAPshot.

Figure 15 Example of SNAPshot System Date error screen


Snap
Error in field Episode:BegDate (Episode begin date):
BegDate must be between System Beg/End dates (01/01/1999 to 31/12/2015)
OK

This error is easily fixed:

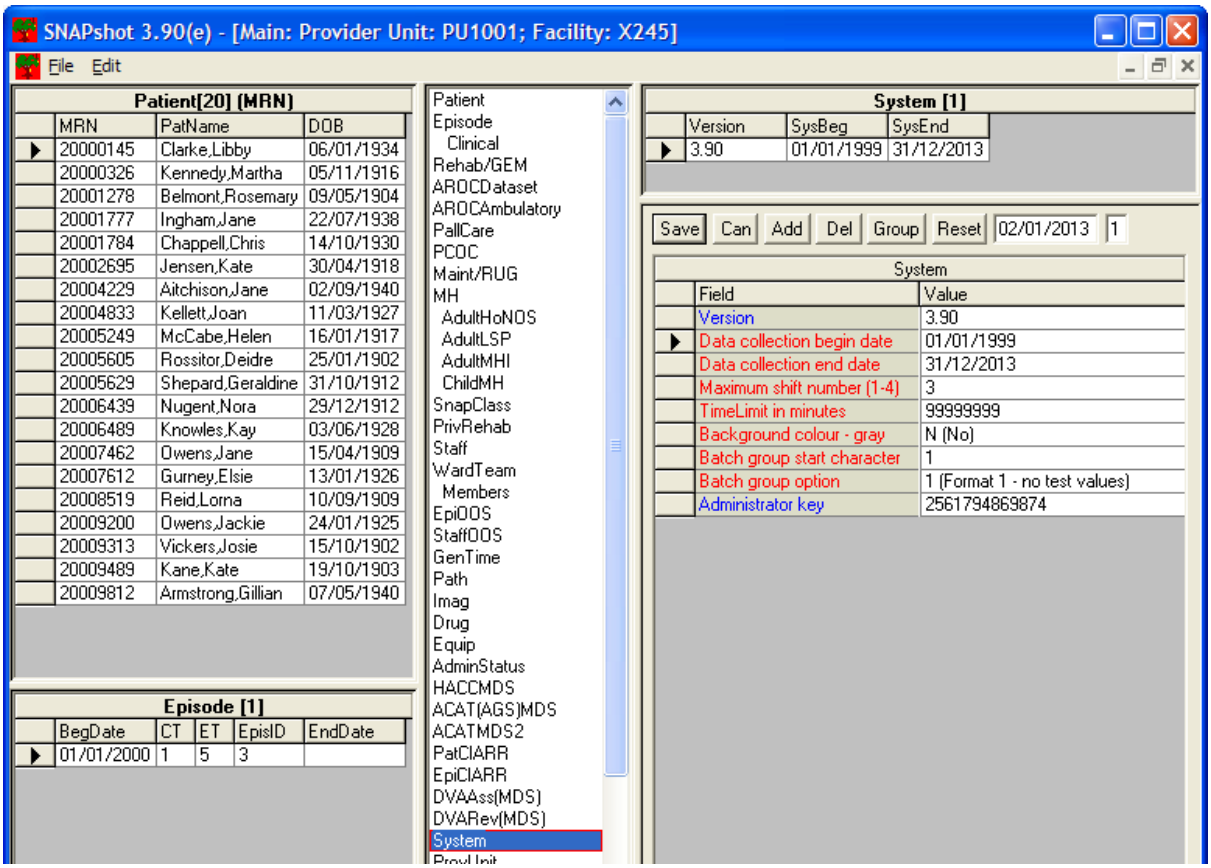
1. Select **System** from the set list.
   This will bring up the SNAPshot system settings screen (Figure 16).

2. In the system screen next to the *Data collection end date* field you should see a date that is earlier than today's date. Set this date to a date in the future (for example, today's date in two years time).

3. Press *Enter* to move out of the field and then click on **Save.**

You should now be able to enter records without being seeing this error message.

Figure 16 Example of the SNAPshot system screen



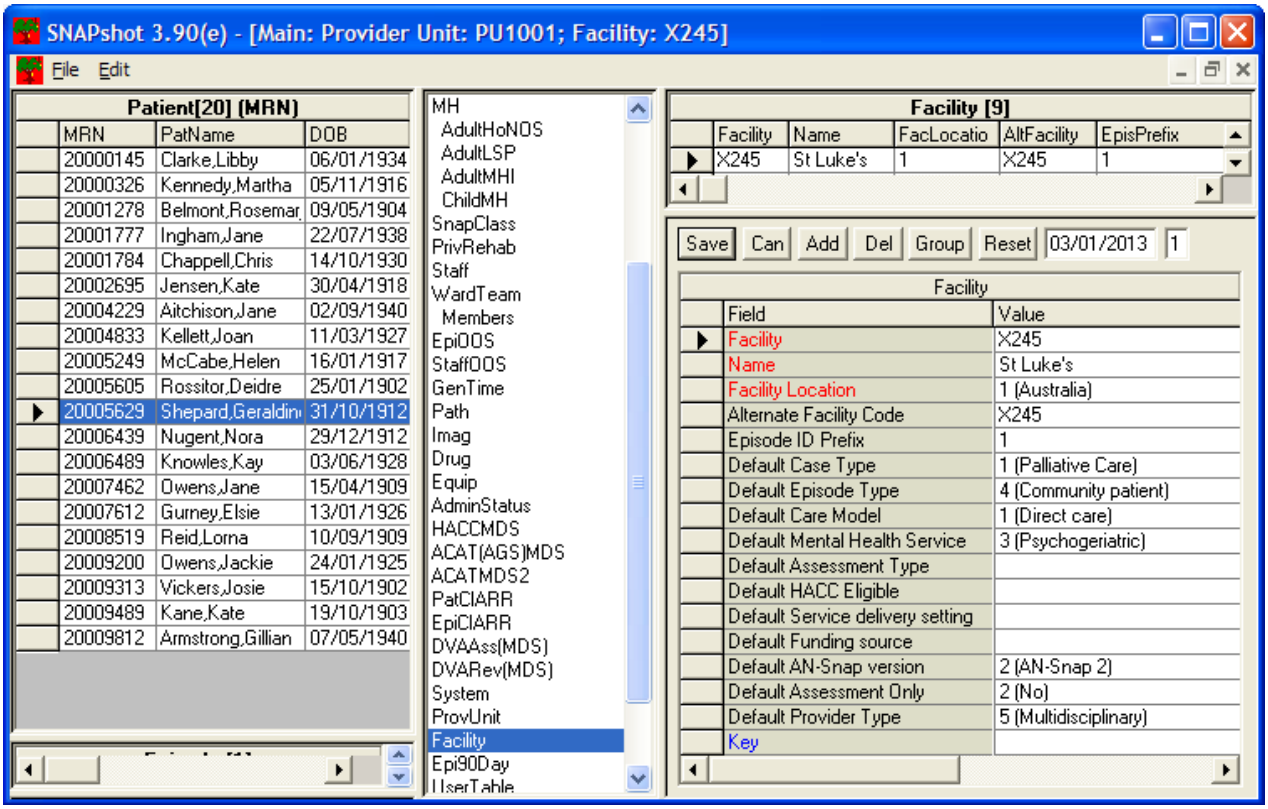
Appendix 1 Initial setup of SNAPshot 3.90

If you have installed SNAPshot for the first time, you will need to enter some information about your Facility/Service, Provider Units and Palliative Care Teams. You can also set up default values to reduce the burden of data entry.

A1 The 'Facility' screen

The Facility Screen contains information to identify the facility/service. It is set up once, usually by the IT administrator at your site or the person installing SNAPshot.

Figure 17 Example of the SNAPshot Facility screen



On the SNAPshot screen you will need to enter information identifying your service/facility. In the *Facility* field, enter the 4-character FacilityID code that PCOC has assigned your service. Please contact PCOC if you do not know your FacilityID. You also need to enter the name of the service in the Name field and the Location (set this to 1 – Australia).

A2 Default Values

In addition to setting up the information identifying the facility, default values can be set in the facility screen. For example, Case Type can be defaulted to Palliative Care (1). The following fields can also be defaulted:

- Default Case Type – set to '1', Palliative Care
- Default Episode Type – set to 0, 1, 2, 3 or 4 depending on your service
- Default Care Model - this item is not required in PCOC however it is a mandatory item in SNAPshot hence the need to default
- Default AN-Snap Version - set to 2 (AN-Snap 2)
- Default Assessment only (set to 'No') - this item is not required in PCOC however it is a mandatory item in SNAPshot (hence the need to default).

Please note that for any patient not in hospital, the following additional data items are mandatory fields in SNAPshot and must also be entered:

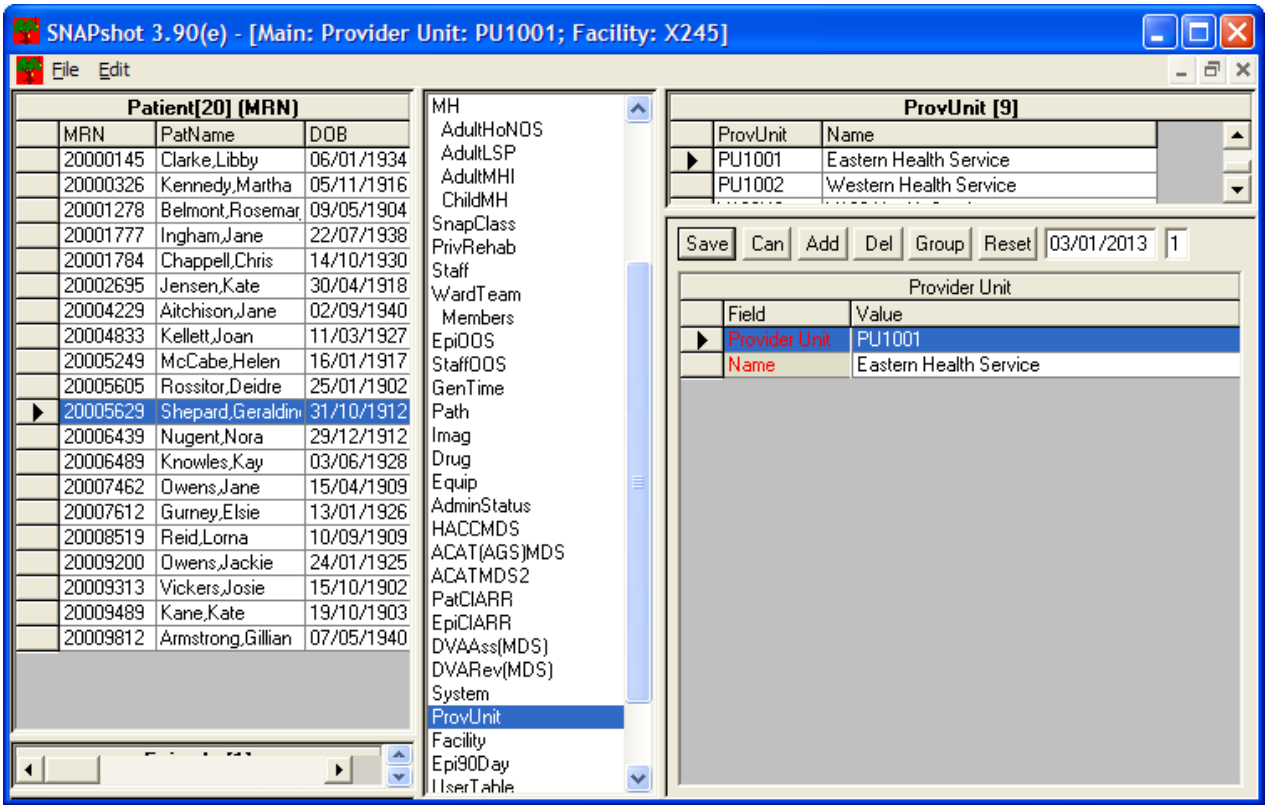
- Provider type - Please select from the drop down list the most appropriate Provider type
- Sole practitioner - Please select from the drop down list the most appropriate code for Sole practitioner

A3 The 'Provider Unit' screen

The Provider Unit screen contains information to identify the provider unit. Typically there is a unique provider unit associated with each medical record system. In practice, this means that for most facilities there will be one provider unit. In this instance enter the same 4-character code in the *Provider Unit* field that you used for the FacilityID code that PCOC has assigned you. You will also need to enter the name of the provider unit in the *Name* field.

Please note: Some larger palliative care service providers may have multiple facilities or service providers with a shared medical record system. In this instance there will be one Provider Unit common amongst numerous facilities.

Figure 18 Example of the SNAPshot 'ProvUnit' screen



A4 The 'Ward/Team' screen

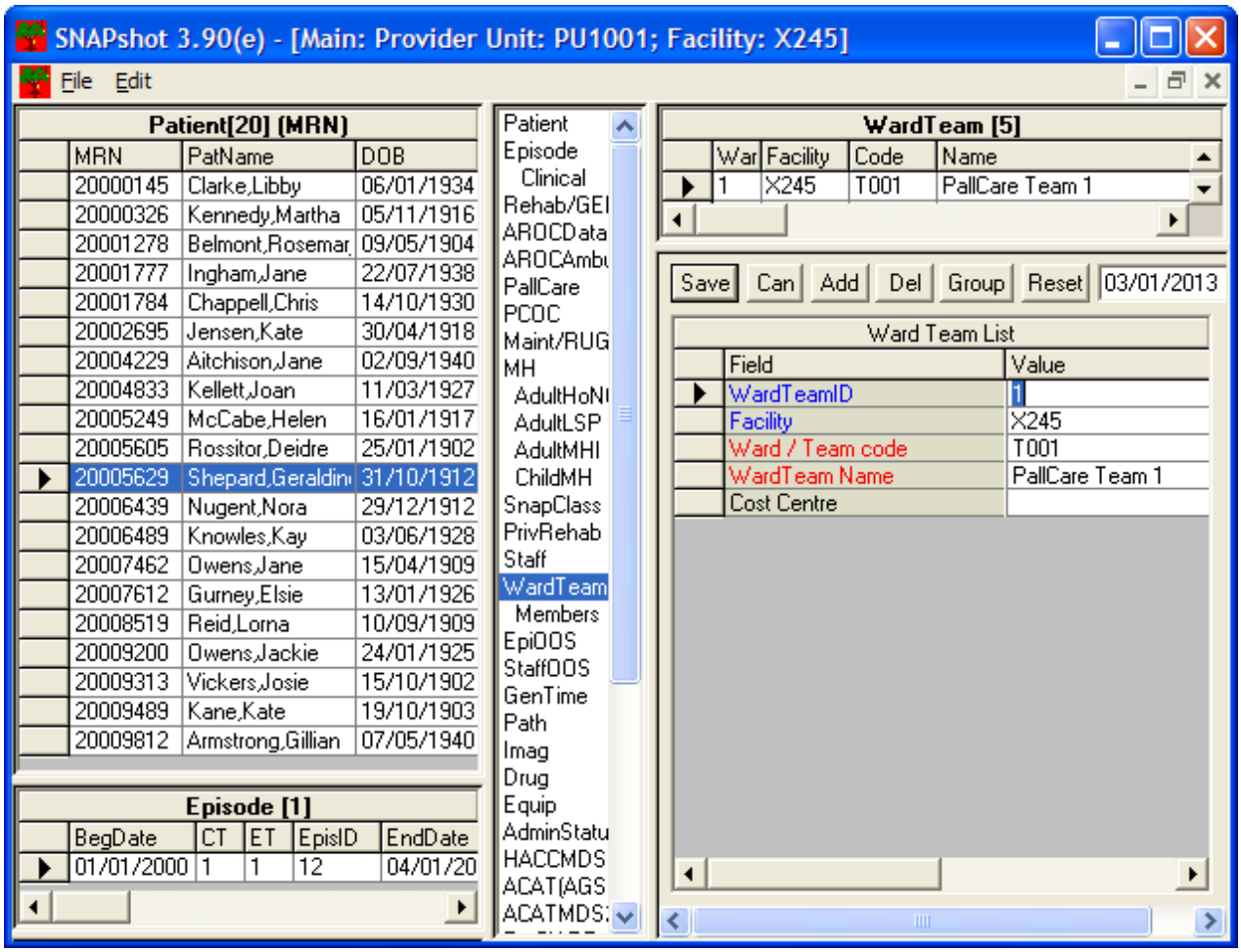
If your service has more than one team (for example a dedicated inpatient team and a separate consult team) you may be required to record which team was responsible for providing care in the episode screen.

To set up a team:

1. Highlight the Ward/Team entry in the set list and click **'Add'**
2. In the '*Ward / Team code'* field enter a 4-character identifier for the team
3. In the '*WardTeam Name'* field enter the name of the team to be associated with the 4-character code.

Please contact your PCOC Quality Improvement Facilitator if you have any questions regarding Teams at your service/facility.

Figure 19 Example of the PCOC 'Ward/Team' screen



Appendix 2 SNAPshot Keyboard Shortcuts

Key	Action
Arrow keys	Move left, right, up or down.
Enter or Tab	Save field changes (if any) and move to the next field to the right or down.
Shift+Tab	Save field changes (if any) and move to the previous field to the left or up.
Alt+down arrow	For coded fields – open the drop down list.
Ctrl+A	Add a new record.
Ctrl+S	Save the current changes.
Esc	If the field in edit mode cancel field changes. In record edit mode, cancel record changes. If you are positioned in the EditView but are not currently editing, pressing the Esc key will move the cursor to the Date field and you can move forward to the Shift field by pressing the Tab key or back to the control buttons using Shift-Tab. Pressing the Tab key on the Shift field will move you to the EditView. If you press the Esc key on the Date field, you will jump to the SetList and you can move up and down the SetList without selecting a set by holding down the Shift key whilst you press the Up/Down arrow keys.
Shift+Up/Down	(on SetList) You can move up and down the SetList without selecting a set by holding down the Shift key whilst you press the Up/Down arrow keys. When you are positioned on the required set, release the Shift key and the set will be selected.
F6	The F6 key will move you forwards from segment to segment. Shift-F6 will move backwards.
F7	F7 is the 'Process' key and, for certain segments/data sets, provides additional processing options.

Appendix 3 Searching for a Patient by Name or by MRN/URN/UPI

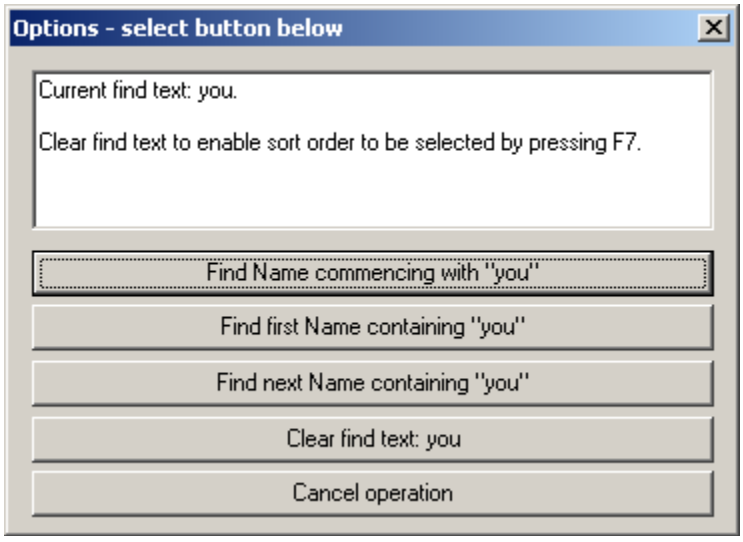
You can search for a patient in the 'Patient list' by surname or by Medical Record Number (MRN).

- Click in the 'Patient List' (or press the F6 key to move the cursor to it).
  If the patient list ordering is by Name, then [Name] will appear in the caption bar. If the patient list ordering is by MRN, then [MRN] will appear in the caption bar.

- Press the F7 key to reorder the list of patients by MRN or Name as preferred.

- To search by Name, order the patient list by name.
  Type the family name (the whole name or the first few letters). The letters you type will appear immediately to the right of [name] in the caption bar. Press the F7 key. Choose from the 'Options' Window in Figure 20.

Figure 20 Searching for a patient record


Options - select button below
Current find text: you.
Clear find text to enable sort order to be selected by pressing F7.
Find Name commencing with "you"
Find first Name containing "you"
Find next Name containing "you"
Clear find text: you
Cancel operation

Alternatively, press Shift+F7 at the same time. SNAPshot will automatically search for the first record that matches your selection. If the first record found is not the required one, press F7 and choose the option 'Find next Name containing…'.

- To search by MRN, type the required MRN and follow the same procedure as for searching by Name.